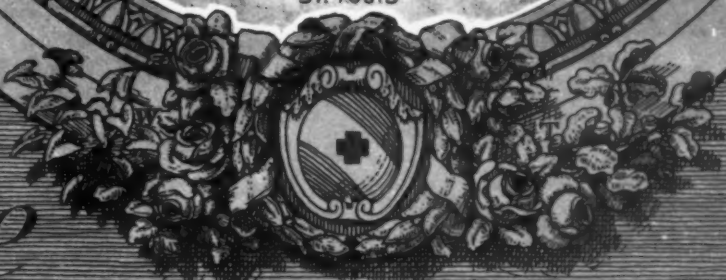


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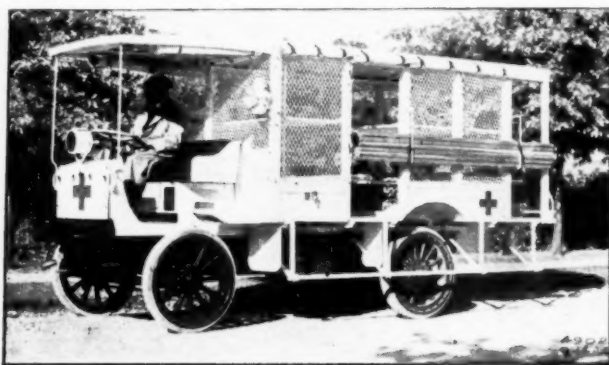
Vol. IX

September, 1917

No. 3



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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to their Medical, Surgical, and Nursing Services

Vol. IX

September, 1917

No. 3

THE HERMAN KNAPP MEMORIAL EYE HOSPITAL, NEW YORK CITY

Hospital and Dispensary Service Exclusively for Ophthalmic Cases—Complete and Extensive Equipment for Therapy and Research—Ward Beds Arranged for Use in Operating

By ARNOLD KNAPP, M. D., EXECUTIVE SURGEON OF THE HOSPITAL, NEW YORK

THE Herman Knapp Memorial Eye Hospital is an outgrowth of the New York Ophthalmic and Aural Institute, which was established in East Twelfth Street, New York City, in 1869. The hospital was founded through the efforts of the late Dr. Herman Knapp, who was its executive surgeon for forty years.

When a change in the character of the district in which the original hospital was located made it necessary to remove to another district, the trustees decided upon a site farther uptown and at the same time changed the name of the hospital so that it might be a memorial to Dr. Knapp and a recognition of his distinguished service in the field of ophthalmology generally, and particularly in this hospital. The new hospital is in the vicinity of Roosevelt Hospital, the Sloane Hospital for Women, Vanderbilt Clinic, and other hospitals, and is conveniently located for the class of people treated in the dispensary.

The hospital treats eye cases exclusively and has

a very large dispensary service, the number of new out-patients treated in 1916 having been 7,625, and, since the founding of the hospital, 439,709 dispensary patients in all cases treated gratuitously, and charged no registration fee. The medicines are dispensed at a really nominal price; eyeglasses are sold at wholesale rates to those patients who can afford to pay something for them, and are given to those who are too poor to pay anything.

The work of the hospital also includes a school of ophthalmology for postgraduate courses in this science, and scientific research is also conducted, the results of which are published in the medical press, chiefly in the *Archives of Ophthalmology*.

The new building of the hospital is at the southwest corner of Fifty-seventh Street and Tenth Avenue, each of these streets being 100 feet



Fig. 1. The Herman Knapp Memorial Eye Hospital, New York, an institution which receives both out-patients and in-patients for the treatment of ophthalmic diseases exclusively.

wide, so that excellent light is afforded to all stories of the hospital. The building is seven

stories high, with well-arranged basement and sub-basement.

The sub-basement is given up to the mechanical plant—heating boilers, coal storage, pumps, water heater, and other apparatus.

The basement is occupied by the general service department, the kitchen, refrigerator room, servants' dining room, laundry, carpenter's shop, and general store rooms being in this story. Adjoining the service entrance there is a receiving room for



Fig. 2. One of the general wards in the Herman Knapp Hospital.



Fig. 3. Main operating room on seventh floor of Herman Knapp Eye Hospital.

the storage of supplies in bulk, and from this room supplies are issued to the various departments.

The first story is entered from both fronts, the north entrance being used by hospital patients and the east entrance by clinic patients. The offices and a reception room adjoin the hospital or in-patients' entrance. The southerly part of the first floor contains a large waiting room. The patients are entered in the registry book in this room, and receive their clinic cards. The memorial tablet to

the founder of the hospital is placed on the south wall of this waiting room. In addition to patients' toilets, there are rooms for the optician and the druggist, and also rooms for the attending surgeons.

The second floor contains a small waiting room, an examining room, a refraction room, and a small operating room, all of which are used by the clinic. There are dark rooms adjoining the examining room and refraction room. In the second story there is also a class room, with its separate

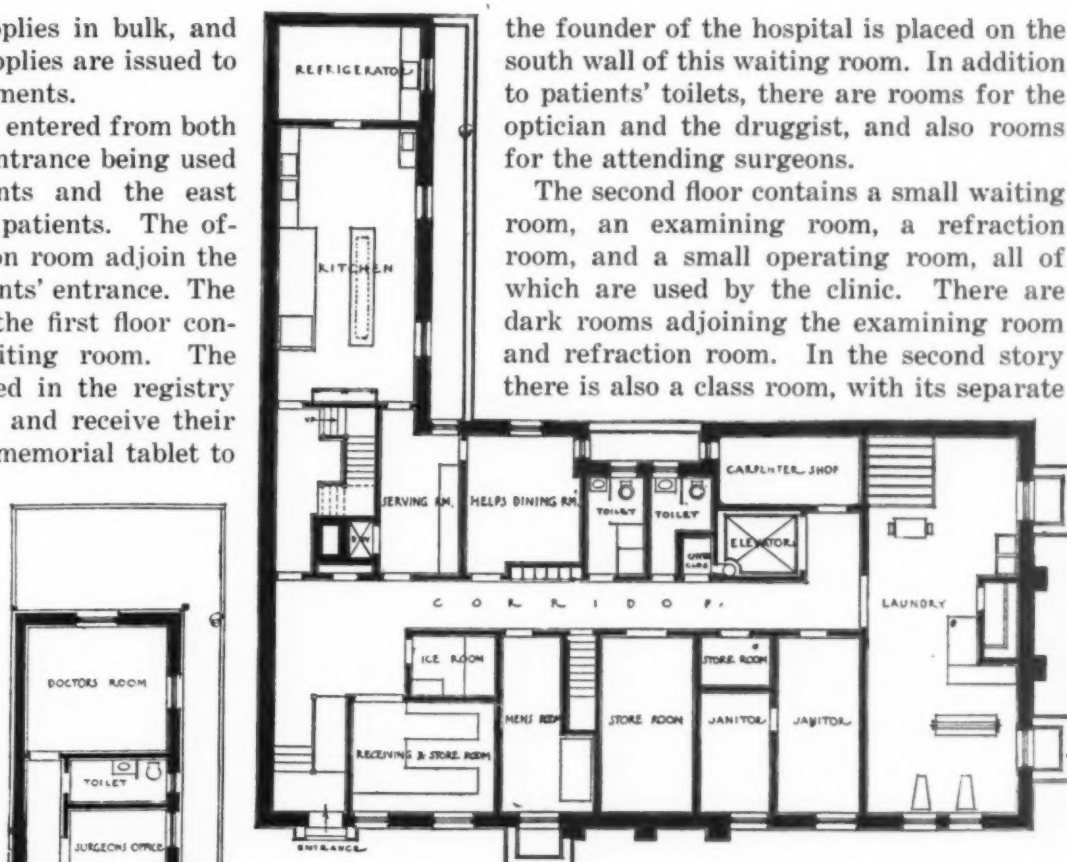


Fig. 4. Basement floor of the Herman Knapp Hospital, devoted to the service department.



Fig. 5. First floor of the Herman Knapp Hospital, containing waiting room for clinic patients, reception room for hospital patients, offices, etc. The clinic patients enter on the Tenth avenue side and the hospital patients on the Fifty-seventh street side.



Fig. 6. Second floor of the Herman Knapp Hospital, containing waiting room, examining room, refraction room, and operating room for clinic patients, together with class room and dark rooms

dark room. Provision is made in the class room for a projecting apparatus for use in instruction. There is in each of the large rooms a tap and drain, so that the floors can be flushed. The rooms are all unusually well lighted by having windows which run clear to the ceiling, so that artificial light is not required.

The third and fourth floors are ward floors. The floors are divided into rooms which contain from three to six beds each. This enables the separation of the patients in rooms for oper-

active cases, rooms for treatment cases, and rooms for those with external diseases. The beds are so arranged that they can be used for operating, as the cataract patients are all operated on in their beds. This is made possible by having the beds of a proper height, each with a detachable head. The light in these rooms, on account of the high windows running clear to the ceiling, is excellent. In addition, there is an electric outlet at the foot of each bed for artificial light. There is running water in each one of these rooms. Ventilation is

obtained by the use of the transoms. The artificial light is indirect by means of reflectors. Each floor has, in addition to toilet and bathrooms, a diet kitchen and a day room, as well as a room with guarded windows for delirious cases, which also can be used for contagious cases.

The third floor is used for men and the fourth floor for women and children. In the third and fourth floors there are rooms for the house physicians, each

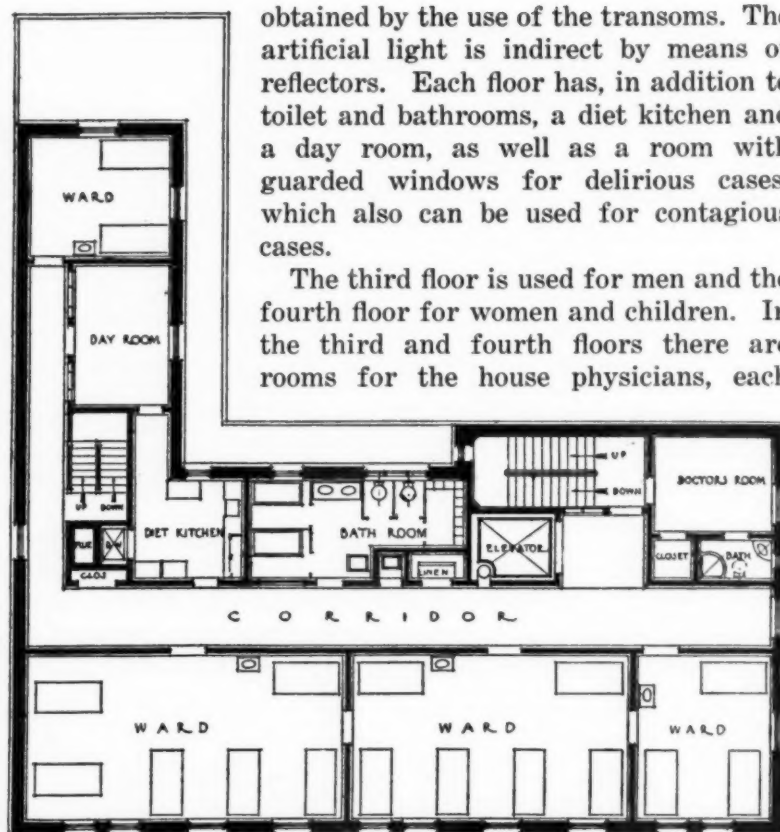


Fig. 7. Ward floors (third and fourth) of the Knapp Hospital. The third floor is for men patients and the fourth for women and children.



Fig. 8. Private patients' floor (fifth) in the Herman Knapp Hospital.

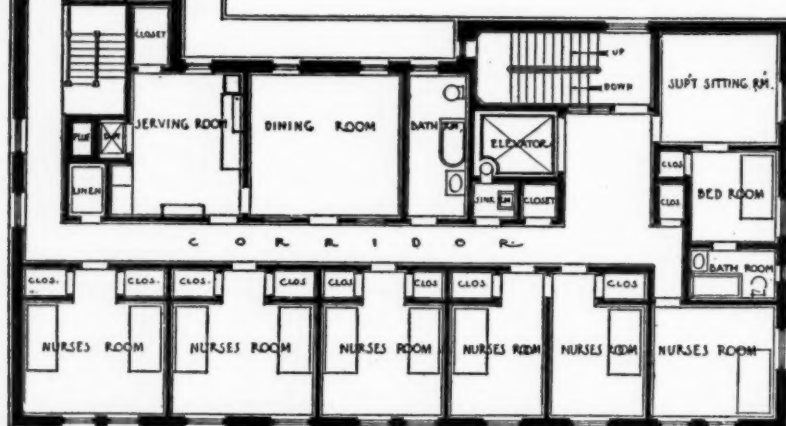


Fig. 9. Nurses' quarters (sixth floor) of the Herman Knapp Hospital.

room having a private bathroom. The fifth floor is used as private patients' rooms, bathrooms, and diet kitchen.

The sixth floor is used by nurses, and, in addition to the nurses' bedrooms, has a nurses' dining room, serving room, and sitting room, and a suite for the superintendent of the hospital.

The northern half of the seventh floor is occupied by the operating rooms, one large room with side light for operations in daylight and another for operations with artificial light (originally planned as an etherizing room and so

designated in Fig. 10). The giant magnet is situated in this room. Adjoining the large room is a room for the sterilization and preparation of dressings. A pathological laboratory and a photographic dark room are on this floor. The southern portion of the seventh story is given up to servant's bedrooms.

The entire roof is available for the use of patients, as it is brick-paved and is surrounded by a high wrought-iron fence.

The building is standard fire-proof construction throughout, skeleton construction, no wood flooring being used except in private patients' rooms, and no wood trim except in the clinic. The main staircase has a fire-proof enclosure and all doors and windows at vulnerable points are fireproof. The building is absolutely proof against the spread of fire within the

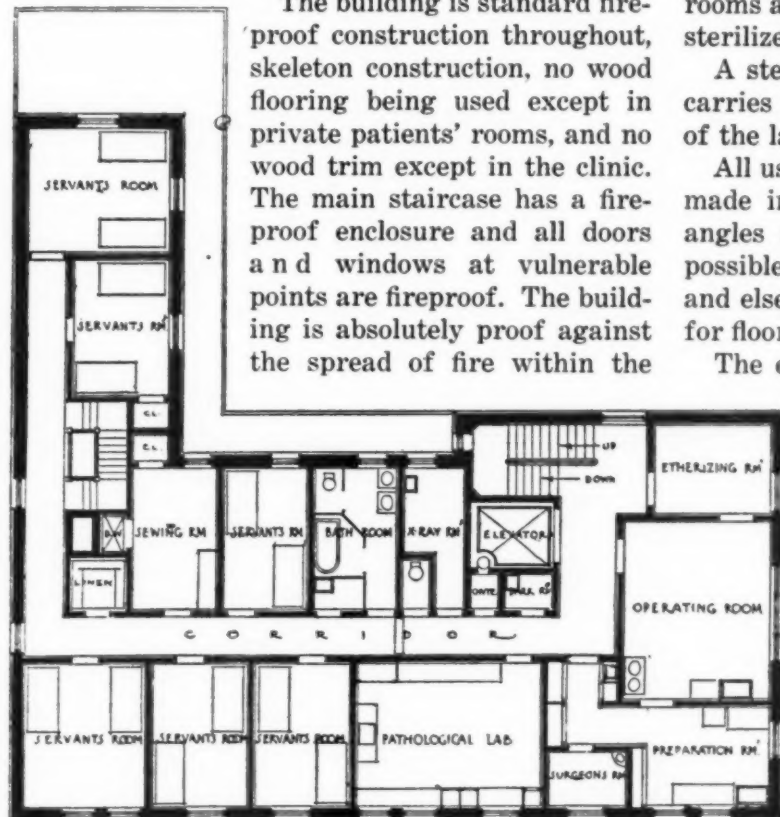


Fig. 10. Seventh floor of the Herman Knapp Hospital, containing operating rooms, room for preparation of dressings, pathological laboratory, and servants' room.

building and against the communication of fire from neighboring buildings.

In each story there is a fire-alarm box from which a call can be sent, and, if any one of these boxes is operated, alarm bells will ring in all stories of the building. The building is provided with a standpipe with fire hose in wall cabinets in each story and with a fire-engine connection in the street.

The elevator is large enough to receive a wheeled stretcher and has a traction-type machine with switch control, all mechanism being in the roof house.

Service from the kitchen to diet kitchens and service rooms in the upper stories is accomplished by means of an electric dumbwaiter with fully automatic push-button control.

The building is heated throughout by direct hot-water radiation, supplied from boilers in dupli-

cate, one boiler being used in moderately cold weather and both in severely cold weather. The heated water all goes first to the top of the building, where the distribution to the various risers is made, this arrangement of piping minimizing the friction in the system.

All water used in the building is filtered, the filters being arranged to remove organic matter and gases from the water in addition to the mechanical filtration. Water used in the operating rooms and for the treatment of patients is further sterilized by heat.

A steel clothes chute, with doors at each story, carries soiled linen to a soiled-linen room outside of the laundry.

All usual provisions for easy cleaning have been made in the building, through the rounding of angles and use of unbroken surfaces wherever possible, and in the operating rooms, toilet rooms, and elsewhere, through the use of tile and marble for floors and walls.

The exterior of the building is Italian Renaissance in style, and is of Harvard brick laid in Flemish bond, and has limestone and granite trim.

The following is quoted from the report of the Board of Trustees following one year's occupancy of the new building:

"The hope that the new location is a favorable one has been realized. The neighborhood is in a crowded tenement district, where no special eye hospital has been within reach. This has resulted in a smaller falling off of new patients than was feared from such a radical move, and at the same time we have been easily accessible to all parts of the city.

"The building itself has also proved all and more than was hoped. On a corner, near the Hudson River, and away from elevated trains, light and air have been a wonderful contrast to the old hospital, which of late years had been surrounded by lofty buildings and fur-curing sweatshops.

"The practical usefulness of the building is entirely free from disappointments. The high transom windows ventilate efficiently even in the hottest weather, and the heating system stood the test of a very severe winter. The arrangements of the various rooms for handling the outpatients have proved well thought out, there being no waste of space or time during dispensary hours. The housekeeping parts of the hospital are well adapted to its needs, and the running of the building is systematized to the finest possible point. The entire equipment has proved perfect.

"We feel that our thanks are due to the architects, Messrs. Crow, Lewis & Wickenhoefer, for the splendid building which they have erected for us, and the painstaking and conscientious work with which they have followed every detail in its construction."

Slight small injuries and they'll become none at all.

THE CLINICAL LABORATORY OF ALBANY HOSPITAL

An Experiment in Laboratory Administration—Coordination of Clinical and Laboratory Activities Necessary for Higher Efficiency—New Positions of Medical Staff Director and Supervising Laboratory Nurse

By CLARENCE F. GRAHAM, M. D., ALBANY, N. Y.

THE problem of the clinical laboratory for the hospital of moderate means has not yet been solved in a manner satisfactory at once to the hospital superintendent, the attending staff, and the resident staff. The superintendent is confronted with the necessity of the expense of a resident pathologist, or of seeing the costly laboratory equipment rapidly deteriorate. In the absence of supervision and of constant attention to details, the laboratories become slovenly and the interns discouraged, and the routine work is done without interest or care, simply as a necessary evil. Many a "sink test" can be traced to a dirty laboratory.

Without proper instruction of the nurses, the blood for the Wassermann will find its way to the incubator and the culture to the refrigerator. Even the presence of a pathologist does not entirely remedy the conditions, unless he be also engaged in the clinical work of the hospital and able to appreciate the peculiar requirements of clinical methods. Even the collection of a twenty-four-hour specimen of urine demands careful attention, if any valid conclusions are to be drawn from its quantitative examination.

The purpose of this article is to describe in some detail an experiment in laboratory administration, which, although still in progress, is already producing results more satisfactory than any before obtained in the particular hospital. If it should evoke discussion and a disclosure of methods that have given good results elsewhere, it may assist in the solution of a difficult problem.

LOCAL PROBLEM

An open hospital of 400 beds, receiving the private patients of from thirty to forty physicians as well as public patients of the attending staff, running two dispensaries, and instructing in its wards the students of an affiliated medical school, finds its laboratory facilities inadequate for proper work. There is no resident pathologist, but the pathological work is done in a corporate

laboratory a stone's throw away, under yearly contract, so that the routine work of the interns is without supervision except such as may be exercised by physicians interested in particular cases.

The previous laboratory facilities had consisted of one room opening from the main corridor and fitted with benches, sinks, and gas. This room had been restocked with apparatus and reagents at least four times in ten years and everything had been dissipated with such amazing rapidity that a tradition had grown up that a laboratory could not be maintained. With no supervision of the apparatus, anything needed in a ward could be taken at once from the laboratory, without the formality of requisition.

It was decided not to attempt any extensive use of this room further, especially since a whole floor in a building formerly used as a nurses' home was standing empty and seemed well adapted for laboratory purposes. This building runs back from the main corridor, and the floor selected communicates with the second-story main corridor by a short flight of steps.

Since the rearrangement consisted chiefly in the provision of a ample bench room and abundant sinks, gas cocks, electric connections and shelves, an architect was not employed, but a member of the medical staff drew the plans and supervised the construction. The saving so effected outweighed the unavoidable crudities of some parts of the work, and this economy can be recommended. The work was done by one of the best builders in the city, who took a personal interest in the success of the undertaking, and to him the good results obtained are largely due. For economy's sake, open construction was used throughout, except for three apparatus cabinets in the chemical room. Besides reducing the expense, this expedient makes the laboratory much easier to clean, and avoids the usual accumulation of rubbish and dust in drawers and cupboards. For the bench tops, poplar treated with the usual chemical finish was employed.

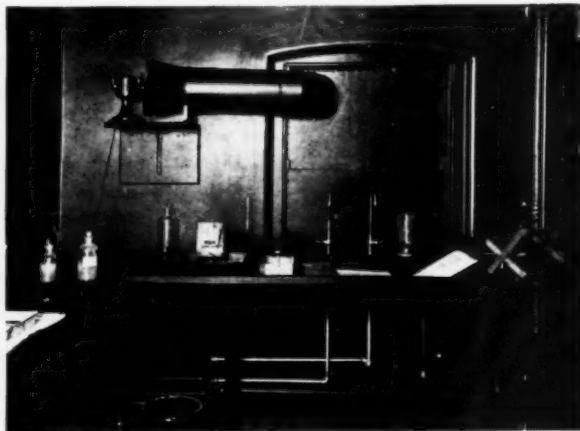


Fig. 1. Ventilating system in the dark room of the clinical laboratory, Albany Hospital.

Twelve rooms of the twenty-two on the floor were utilized. Their description follows:

Dark Room.—Bench on two sides, with a sink measuring 22 by 42 inches, shelves along one side of the room, and a ventilating system. The bench has a hinged section 3 feet long, which lifts up to allow access to a plate rocker. The ventilating system furnishes a constant supply of fresh air by the use of an ordinary 8-inch fan.

Receiving Room.—This room already contained a brine-pipe refrigerator. The installation consists of a bench on three sides with a sink, shelves, a hood for stool specimens, and a refrigerator adapted for use as an incubator by the insertion of a heating unit and thermoregulator combination. This room serves as a receiving station for all

man has his set of reagents in neatly labeled bottles, his own burner, test tubes, funnel, and other apparatus. Each man's name is posted above his bench space, and he is responsible for its condition. The unassigned portions of the benches are used for special work, such as staining and quantitative estimations.

Stock Room.—This room is fitted with benches along two sides, a large sink, and abundant shelf space. The laboratory stock is kept here, and solutions are made up in large quantities and stored in siphon bottles on the shelves, with a drip trough under the delivery tubes of the bottles.

Physical Room.—Benches along two sides, and a large sink. The balances, spectroscope, potentiometer, and nephelometer are mounted in this room, which is free from fumes.

Office.—Desk, typewriter desk, table, filing cases, and a bookcase make up the equipment of this room.

Pathological Room.—This is equipped with sitting-height benches along three sides, a sink with four washing faucets over the drain board, and two stacks of shelves. Dry and steam sterilizers, an electric incubator, and a Barnstead still are installed here and the room is used for research.

Chemical Room.—This room was made from three rooms by the removal of partitions. It contains two chemical benches projecting into the room from the outer wall, and benches on three sides. Three apparatus cabinets cover the inner wall.

There is a fume hood in one corner, ventilated by a fan, and with outside control of gas, water, and electricity. A large centrifuge is permanently mounted on a low stand in one corner, and a shaker on a 300-pound concrete block is suspended below one of the benches by spiral springs which completely take up the vibration. The room is not piped for vacuum and pressure, but a Crowell blower with motor drive is mounted on a low-wheeled truck and can be plugged in on any of the electric receptacles wherever it is needed. For prolonged operation under load the blower is cooled by connection to one of the faucets of the water supply. This arrangement of the blower has proved most satisfactory.

The other equipment of the chemical room follows that ordinarily found in such a department.

The electrocardiograph is also operated as a

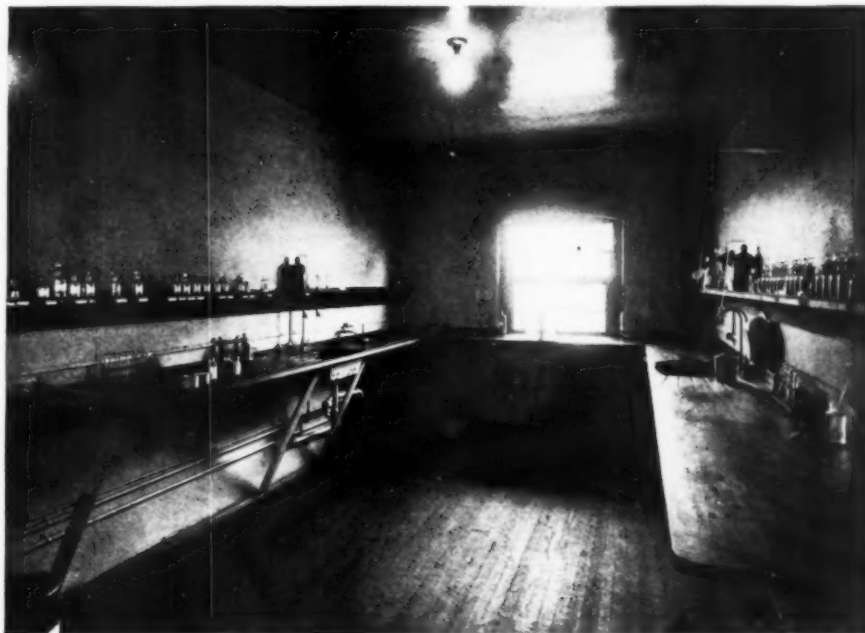


Fig. 2. One of the two service laboratories of Albany Hospital. Each man who works in these two rooms has his own set of reagents in neatly labeled bottles, his own burner, test tubes, funnel, etc., and each man is responsible for the condition of his own bench space.

specimens. Here the bottles are washed, sterilized, and relabeled, and checked out to the wards.

Service Laboratories.—These consist of two rooms, each fitted with standing-height benches on three sides, a sink in each side-wall bench, and a single reagent shelf along each side wall. Each room has a microscope by the window, and a small electric centrifuge in the corner farthest from the light. The centrifuges are mounted on small squares of orthopedic felt placed directly on the benches, and produce no noticeable vibration when running. The controlling rheostats are arranged with the first contact a dead point, and no switch is used. It is, therefore, impossible to start the machine with a jerk, since it can be stopped only by turning the rheostat back to the starting contact.

Four men work in these two rooms, and each

branch of the clinical laboratory, and the apparatus is mounted on the main floor of the same building and has its own dark room. The wards are wired in the usual manner.

So much for the physical plant. It was recognized even before the construction of the laboratory that its administration would be the real problem on which the whole success of the undertaking would depend, since the previous laboratory had failed for want of adequate supervision. Two administrative positions have been created, which are, perhaps, new in laboratory management, that of the medical staff director, and that of the supervising laboratory nurse. The director is a member of the dispensary staff and an instructor in medicine of the medical college, so that he is in close touch with the medical staff of the hospital. His connection with the attending staff allows him to discover the needs and aims of

interns—with the firm conviction that contented workers make good work.

As the director makes the contact between the laboratory and the medical staff, so the supervising laboratory nurse makes the equally essential contact between the laboratory and the nursing staff. She devotes her whole time to the laboratory, and ranks with the ward supervisors. Her duties already are numerous, and expand constantly as the routine becomes more automatic; in fact, the holder of this position can make of it almost what she will. At present the supervising nurse's duties comprise the general oversight of the laboratory housekeeping, the making up of solutions, the replenishment of stock, the checking out and care of apparatus, the collection of the laboratory reports and their delivery to the wards, the checking of specimens for delivery to the pathological laboratory, and the operation of the

electrocardiograph. In addition, she conducts a clinical pathology course for nurses. At first glance this seems a formidable list, but the work involved has been reduced by various expedients and short cuts.

The cleaning of the laboratory is done by a man who devotes his whole time from 7 a. m. to 5 p. m. to this work and other tasks in the department. He has so developed a sense of responsibility that he needs no oversight—in fact, he takes the greatest interest in all the laboratory routine. It is absolutely necessary that such an attache should be able to use tools well, for repairs and alterations are



Fig. 3. Laboratory of Albany Hospital, showing open construction.

the medical body, while his control of the laboratory enables him to meet the requirements of the clinical departments. Without some such coordination of the clinical and laboratory activities there is certain to be lost motion and diminished efficiency. The director has undertaken the preparation of rules for the collection of the various clinical specimens for examination in the laboratories, and has arranged for suitable containers. He has outlined the method of entering the reports in the ward histories, drawn up the forms, and devised filing systems for the preservation of necessary records of the work done. All this, of course, has been after consultation with the attending staff, so that their ideas and desires are incorporated in the system. In his relation to the laboratory, the director has also tried to meet the wishes of the men who do the actual work—the

constantly needed where so much apparatus is in use. A small workshop has been fitted up for this purpose, and is a daily convenience.

The laboratory solutions are made up in large quantities, and a typewritten list of formulas is posted in the stock room for quick reference. Stains are kept in the refrigerator in saturated alcoholic solution, and diluted as needed. Wright's stain is made up from the Burroughs-Wellcome tabloids at frequent intervals. Dirty slides are collected in wire baskets and boiled in cleaning acid, a thousand at a time, to be used over and over. Litmus solution is used instead of paper for testing the reaction of urine. Replenishment of stock is made monthly as far as possible in order to cut down the number of orders sent to the dealers. In the stock room a slate is hung, on which needed supplies can be noted.

Apparatus is checked out of the stock room to the interns as individuals, and each man is required to sign a receipt for such things as blood counters and hemoglobinometers. For such special procedures as the quantitative determination of glucose, chlorids, and gastric acidity and for the phenolsulphonephthalein test, separate sets

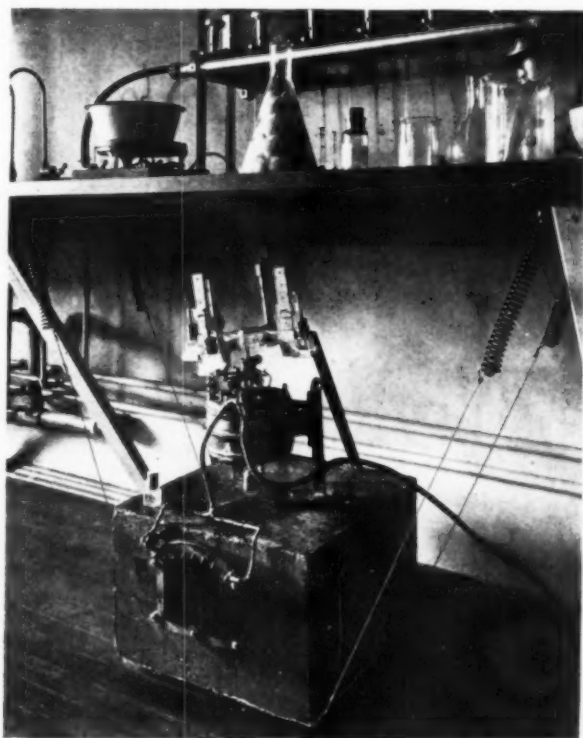


Fig. 4. Shaker mounted on a 300-pound concrete block suspended by spiral springs which completely take up the vibration.

are kept always in readiness on wooden trays about 18 by 24 inches in size. This obviates the necessity of collecting all the different pieces of glassware, filter paper and reagents every time a determination is made, and has proved a great time-saver. Of course, there is some duplication of apparatus by this method, but it is possible to have everything the best obtainable, since the trays are checked out and examined when they are returned. Typewritten directions for each procedure are mounted under glass on the corresponding trays.

The use of individual trays in this way is capable of extension to many other procedures, with good results in the saving of time and apparatus. It is a well-known fact that a large part of the time required for any clinical chemical procedure is taken up simply in assembling the apparatus and reagents and refreshing the memory as to the steps, while the actual operation is usually rather short. Such trays might well be made up for spinal fluid examinations, blood cultures, stool cultures, frozen section work, milk analysis, and other operations which are done only from time to

time under the conditions of any particular laboratory. The trays can be stored where they do not take up the working space, and are immediately available when needed. With the reduction of hospital staffs to the minimum, every saving of time and labor becomes important.

In the matter of laboratory reports also certain time-saving features have been introduced, with the inevitable disadvantages which accompany short cuts. Two forms of laboratory sheet are provided, and a separate sheet is used for each report, unless the same worker happens to carry out several procedures on a single case at one time, when the reports are combined on one sheet. The disadvantages of this method are that it makes the ward history bulky if much work is done on any one case, as may occur with nephritis, diabetes, or blood diseases, and that it is wasteful of paper. On the other hand, it permits the original signed report to remain in the history as a legal record, and it eliminates transcription of reports, with the

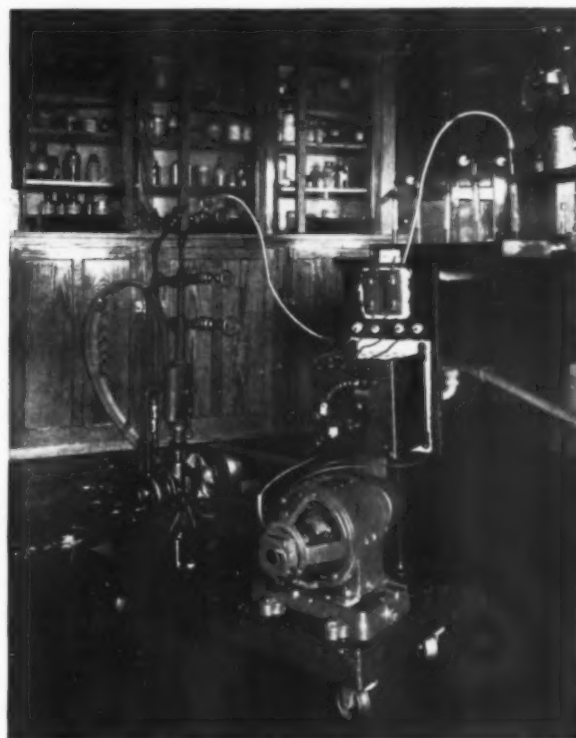


Fig. 5. Crowell blower with motor drive mounted on a low-wheeled truck for use in the chemical laboratory. It can be plugged in on any of the electric receptacles wherever required.

attendant errors and waste of time. Inexpensive paper can be used, since the sheet is written on but once. This method of entering the laboratory reports was decided upon after several other methods had been thoroughly tested and found too time-consuming. Naturally, the histories do not look as well, but here again economy outweighed esthetics.

The reports of the chemist are entered on the

same laboratory sheets, and all of the laboratory reports are delivered to the wards by the supervising nurse, who makes the rounds of the hospital two or three times a day. Wire baskets are provided in the laboratory to receive the reports, and the intern's duty ends when he leaves his report in the basket. Consequently there is no delay in the delivery of reports because the interns forget to leave the reports when they are in the wards, as so often happens if the intern must both do the laboratory work and deliver the report.

The chemical work of the laboratory is under the supervision of the professor of physiological chemistry of the medical college, who acts as consulting chemist. His assistant, a young woman



Fig. 6. Tray for the estimation of dextrose. Sets are kept in readiness for use, thus preventing loss of time in collecting apparatus.

with a good college training in chemistry, devotes her mornings to the hospital work and her afternoons to work at the medical college.

There is no question that the greater part, if not all, of the routine clinical laboratory work in the ordinary hospital could be done by well-trained non-medical assistants, for this is already an established method in many laboratories, and produces satisfactory results. Where the amount of routine warrants, a separate technician can be trained for each procedure, as urinalysis, blood-counting, bacteriological examination, and the other common clinical methods. With the imminent reduction in the medical staffs of all hos-

pitals, it is here that the first reduction of the interns' work will probably have to come. With this probability in mind, classes of volunteer assistants have been organized to carry on the laboratory work and other related tasks, in order to free the medical staff from routine, and allow them more opportunity for a higher type of duties. By announcement in the papers, volunteers were secured from among the young women of the city, and over a dozen are now in training as clinical assistants. Classes in urinalysis and blood-counting meet twice a week for two-and-a-half-hour periods. The chemist has two understudies who have had some chemical training, and they have already mastered the preparation of a correct Dakin's solution. Several assistants in the x-ray department are learning the operation of the apparatus, the giving of barium meals, and the development of the plates. Dispensary and follow-up work have been taken up by several others. Although the plan is still in the experimental stage, the results so far achieved amply warrant continuation. There is no reason why all routine laboratory work, anesthesia, history taking, operation of the x-ray machine and therapeutic apparatus and many other duties could not be carried on by properly trained women, provided there be adequate and frequent supervision of their work.

Tuberculosis Hospitals in New York State

With a view to mobilizing all resources which will assist the counties of New York State in carrying out the provisions of the recently enacted law requiring the construction of tuberculosis hospitals in counties of 35,000 population or more, Dr. Hermann M. Biggs, state commissioner of health, has appointed two committees which are to take entire charge of the tuberculosis situation in the state. The first committee, which is headed by Dr. John A. Smith, secretary of the department, will have general supervision of sites, plans, construction, and equipment of tuberculosis hospitals, and will carry on the anti-tuberculosis campaign in the state. The second committee, which is composed of some of the foremost authorities on the subject in the state, will act as an advisory board.

With Dr. John A. Smith on the first committee will be Dr. O. R. Eichel, as vice-chairman; Dr. E. S. McSweeney, as secretary; George J. Nelbach, of the State Charities Aid Association; C. A. Holmquist, as engineering expert; Frederick Sprenger, as construction expert; J. D. Burt, as architect, with Dr. Matthias Nicoll, Jr., deputy commissioner of health, as a member of the committee ex officio.

The advisory committee consists of Dr. Albert H. Garvin, superintendent of the New York State Hospital at Raybrook; Dr. John S. Billings, of New York City, medical director of the New York Telephone Company; Dr. Charles Stover, of Amsterdam, president of the board of managers of the Montgomery County Tuberculosis Hospital; Dr. Horace J. Howk, physician in charge of the Metropolitan Life Insurance Hospital at Mt. McGregor; and Dr. Lawra-son Brown, of Saranac Lake.

THE GOVERNMENT'S WORK IN THE ERADICATION OF TRACHOMA*

Magnitude of the Problem—Heavy Infection in the Appalachian Mountain Region—Increase of the Disease—Six Free Hospitals Established by the Government to Treat and Educate Sufferers and Prevent Spread of the Disease

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FOR the past twenty years any alien arriving in this country and found to be suffering with trachoma was deported to the country whence he came, as the government has declared this to be a dangerous contagious disease and its deportation is mandatory.

Trachoma has usually been considered as an exotic disease, and our immigration laws have been relied upon to exclude it from the country. Investigations by the United States Public Health Service for the past few years, however, show that

tion showed that 1,280 out of 18,000 people examined, 16,696 being school children, were suffering from trachoma. Many of these children were unable to attend school except irregularly during the remissions of the disease. Adults were greatly handicapped in earning a livelihood; many were practically blind and others totally so from trachoma. Large numbers of people in those sections where trachoma is prevalent suffer untold agony from this disease, and the deformities and mutilations resulting are mute evidences of its destructive power, presenting sights pathetic in the extreme.

There is no disputing the fact that trachoma is communicable, and there is no lack of evidence that this disease is decidedly on the increase. During the survey old cases were found which had existed for generations and had been the direct cause of numberless victims, and, where the total number of cases were in the hundreds, it is now in the thousands.

This army of trachoma cases is not confined to any one state; the victims travel at will, carrying their infection with them without let or hindrance from one state to another, and prevention of the spread of trachoma in interstate traffic is what particularly interests the general government.

It is realized that the widespread dissemination of trachoma constitutes a serious public health problem in this country, and the United States Public Health Service undertook some years ago to demonstrate methods for the eradication of this disease and the prevention of its further spread. With this end in view, small free hospitals were established in the infected districts where they would be accessible to those suffering with trachoma.

The first hospitals established were about twenty-five miles from the railroad, but when the hospital was no longer needed in one section it was removed to another, and in this manner the field of usefulness of each hospital was enlarged. The hospitals are now six in number, and all of them situated on the railroad, as they are accessible to more patients, as follows: Jackson, London and Pikeville (Kentucky); Coeburn (Virginia); Welch (West Virginia); and Tazewell (Tennessee). Two of these hospitals have a capacity of twenty-five beds each and the other four of twenty beds each. Each hospital is in charge of a physi-



Fig. 1. An illustration of the need for the service rendered by the government trachoma hospitals. This girl, aged 18, states that for about ten years she has been unable to open her eyes on account of trachoma. At the time this photograph was taken her disease had made her an inmate of the poorhouse in Muhlenberg County, Kentucky.

thousands of cases of this disease exist in various sections of the country. A heavy infection has been found among the Indians and some sections of the Appalachian Mountain range. In other sections it has been found more or less prevalent. The heaviest infection has been found in the Appalachians, about where the states of West Virginia, Virginia, and Kentucky are adjacent. A survey made of twenty-three counties in this sec-

*Articles on trachoma have appeared in THE MODERN HOSPITAL as follows: "Trachoma in the Mountains of Kentucky," by J. A. Stucky, July, 1915, page 51; "Trachoma in the United States," by Gordon L. Berry, November, 1915, p. 368.

cian who has had special training in eye, ear, nose, and throat work, and a complement of trained nurses and attendants. Only active trachoma is admitted to the hospitals, but in the dispensary practically all conditions and diseases of the eye are treated among those who are either too poor or too remotely situated to consult a specialist.



Fig. 2. The "blind leading the blind" as a result of trachoma. The man behind is totally blind and the man in front nearly so.

Upon admission to hospital each patient is informed of the communicable nature of his disease and cautioned not to transmit it to others. Individual towels, cups, etc., are given each patient for use during his stay in the hospital. Absolute cleanliness is insisted upon, and the doctors and nurses give regular talks to patients in the hospitals on various public health subjects, and the reason for maintaining free hospitals is explained. It is endeavored so to conduct the hospitals as to give an object lesson to the patients with the hope that they will emulate the example when they return home.

Dispensary patients are told the nature of their disease and the necessity of using individual toilet articles; they are given popular literature on trachoma, its nature, prevention, etc. After treatment all patients are furnished with a clean gauze handkerchief. The importance of the educational part of the work is recognized and this is furthered by talks in schools, court houses, teachers' institutes, etc., and the distribution of popular

literature on the nature and prevention of trachoma. The doctors and nurses also do district work and visit homes in the remote sections to follow up some of the hospital cases, induce others to come in for treatment, etc. One nurse assigned exclusively to district work rode 4,000 miles on horseback over rough mountain roads in ten months.

During the twelve months ended June 30, 1916, the six trachoma hospitals had a total daily attendance of 19,530 and 112,055 individual treatments were given; 1,880 patients were admitted to the hospitals, and 1,687 operations were performed; 1,153 were under local and 534 under general anesthesia. The sixth hospital was established only during the latter ten months of this period.

In addition to the work done at the hospitals, field clinics have been held in various sections of the country for the purpose of arousing local interest and demonstrating to the doctors the various stages of the disease, its sequelæ, the diagnosis, and the treatment. These hospitals are also used for educational purposes, and doctors and others interested are urged to visit them and see



Fig. 3. The U. S. Public Health Service Trachoma Hospital at Pikeville, Ky., one of the six free hospitals established and maintained by the government for the eradication and prevention of the disease in the Appalachian Mountains.

in detail how trachoma and its various sequelæ are treated, and learn to perform the simpler operations. Considerable attention is given to beautifying yards of the several hospitals by growing flowers and lawns.

The ages of our patients include both extremes of life. At least one-half of the trachoma cases have impaired vision. Ulcer and corneal opacity occur in 25 percent of the cases; pannus in 20 percent; photophobia was present in 33 1-3 percent, and entropion and trichiasis were noted in 10 to 15 percent of the cases. Impairment ranged between slight defects to total blindness.

Treatment of trachoma is surgical in the great majority of cases. The operation of grattage has

been performed in some form from time immemorial, but upon the quality and quantity of this operation depends the result.

The operation as performed in these trachoma hospitals is done with a specially devised forceps for everting the eyelid, two small scalpels, horn spoon for protection of the cornea, Demarres forceps, tooth brush of medium stiffness, mercury bichloride solution of 1:2000 strength, and plain sterile gauze. The eyelid is thoroughly everted and the granules superficially incised and the thickened conjunctiva carefully scarified with the scalpels, care being exercised to include the cul-de-sac. The surfaces are then gone over with the brush and bichloride solution, followed by the thorough use of the gauze. The operation can usually be done under local anesthesia, but in young children and very nervous patients a general anesthesia will be required. Immediately following the operation the everted conjunctiva is washed with boric solution to remove all blood

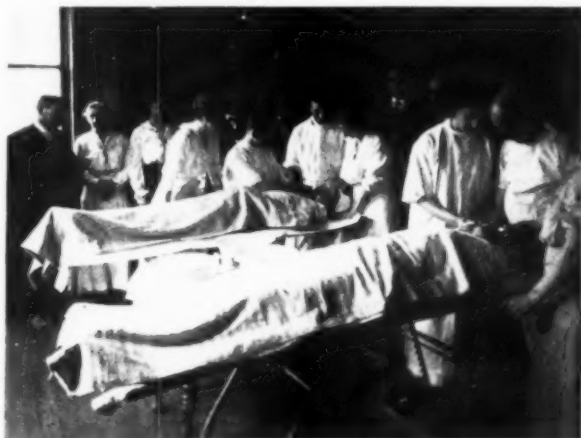


Fig. 4. Patients being operated on at a special clinic held by Dr. John McMullen. Two operating tables are necessary to accommodate the large number applying for treatment during the three days' clinic.

clots and lessen the tendency to adhesions. During the twenty-four to forty-eight hours after a radical grattage, the eye should be under the surveillance of the surgeon or qualified assistant to guard against adhesions and other complications. After-treatment consists of cleansing the eyes carefully every three hours and the use of 20 percent solution of argyrol. After five or six days, if uneven granular or rough surfaces are present, the lids are everted and lightly brushed with a 1 or 2 percent silver nitrate solution, repeated as necessary and as the individual case will stand.

The various sequelæ are given the necessary treatment. Patients suffering with entropion, trichiasis, central opacities, etc., are often given the greatest relief. When a cure has been effected the case is refracted and glasses prescribed where warranted.

The service method of establishing hospitals in

trachoma centers has proved entirely satisfactory, and the results are extremely gratifying. Adults who had suffered from trachoma for years, and were dependent upon their friends or the county for support, have been relieved, and are no longer a menace and have taken their place in the community and earning a livelihood for themselves and family. Children unable to obtain an education on account of the constant physical suffering



Figs. 5 and 6. Before (left) and after (right) operation. This 10-year-old child was practically blind and suffering from extreme photophobia when admitted to the hospital. She is shown on the right about three months after the first operation with complete recovery and very fair vision.

and impaired vision are now able to attend school regularly. During the fiscal year 1916 there were 1,500 cures effected.

It should be remembered that the majority of the patients treated in these hospitals are without means, would otherwise never have been given relief and remained a menace to their community. The total cost of maintaining these hospitals, including salaries of the doctors, nurses and attendants, is about twenty dollars a day each.

The Sisters of Bon Secour will shortly open a new hospital at Fayette and Pulaski streets, Baltimore. Fifty private patients can be accommodated. There will be no public wards. The order has been established in Baltimore for 25 years and conducts a convent and a day nursery there. It also maintains day nurseries and hospitals in Philadelphia, Washington, and Detroit.

The Doctor

Ah, who would choose to be a Doctor—
A Microbe-stalking Pill-concocter!
At 3 a. m. they ring his Bell
Because some Fellow's dined too well.
He has to leave a Joyous Frolic
Because a Baby gets a Colic;
And while subduing Mortal Ills
With Jalap, Ipecac, and Squills,
He has to hear the Conversations
Of Patients, matching Operations;
And then, to crown his Pain and Strife,
They vilify him here, in "Life."

—Arthur Guiterman in "Life."

AN EMERGENCY HOSPITAL FOR THE AFTER-CARE OF INFANTILE PARALYSIS

Heavy Incidence of the Disease in the Borough of Brooklyn—Emergency Hospital Supported by Funds Raised Through the New York American

BY LOUIS C. AGER, M. D., BROOKLYN

AS in 1907, so in 1916, the brunt of the burden resulting from the epidemic of infantile paralysis in Greater New York has fallen upon the borough of Brooklyn. The *Weekly Bulletin* of the Department of Health for October 7, 1916, shows that Brooklyn, with scarcely more than a third of the total population, had nearly half the total number of cases and deaths in Greater New York. In addition to these figures, a comparison of the orthopedic resources of the two larger boroughs still further emphasizes the emergency with which Brooklyn had to deal in the fall of 1916. The borough of Manhattan, which had only 2,512 cases and 658 deaths, as against Brooklyn's 4,512 cases and 1,125 deaths, had in the New York Orthopedic Hospital, the Hospital for the Ruptured and Crippled, the Hospital for Deformities and Joint Diseases, the Post-Graduate Hospital (orthopedic ward), St. Luke's Hospital (orthopedic ward), the New York Foundling Hospital (orthopedic ward), and the Seton Hospital, Nazareth Branch (orthopedic ward), a total of 441 beds and an average daily dispensary attendance of 650. The borough of Brooklyn, with nearly twice as many cases and deaths as Manhattan's, had, in the Long Island College Hospital, the Brooklyn Hospital, St. Mary's Hospital, and the County Hospital a total of only 133 beds and an average daily dispensary attendance of 50.

It is recognized that these figures do not present with mathematical accuracy the complete resources of either borough. A small amount of operative orthopedic surgery is conducted in the general surgical wards in various other institutions in Greater New York, and the actual outpatient attendance is not necessarily a proof that a dispensary is being used to its full capacity. Nevertheless, these two sources of error would probably add a proportional increase to the figures for both boroughs.

During the acute stage of the epidemic it was recognized that the orthopedic resources of the borough of Brooklyn would have to be increased many fold in order to give proper care to the paralyzed children. The Brooklyn Committee for the Care of Crippled Children immediately took steps to increase the facilities at the Long Island College Hospital and the Brooklyn Hospital, and the House of St. Giles the Cripple speeded up as far as possible the construction of the new building in the upper part of the city. At the same

time Mr. William Randolph Hearst came forward with an offer to raise through the *New York American* a substantial sum of money to be used in whatever way seemed best to meet the situation. After several conferences it was decided to organize, somewhere in the newer section of the borough of Brooklyn where a very large proportion of the cases of paralysis had occurred, an orthopedic dispensary and hospital at a distance of several miles from the two older institutions doing the major part of the orthopedic work for the borough. Owing to the very stringent building laws recently adopted covering hospital construction in New York City, there were very few buildings that could be made use of for this purpose without expensive alterations. The construction of a new building was considered, but it was realized that the time required would seriously interfere with the usefulness of the institution for emergency purposes. Fortunately the Brooklyn Association for Improving the Condition of the Poor owned a small building near the desired location, which it lent to the committee in charge of the fund for a period of two years or more if needed. The location was suitable both on account of its distance from the two older hospitals carrying on most of the work and on account of its proximity to the large foci of the disease indicated by the shaded areas. This two-story-and-a-half detached brick building, located at 470 Throop Avenue, is shown in Fig. 1. The building had been used for housing a branch office and a certain amount of industrial employment, so that the floor space was very much cut up by partitions. The well-known architects, Crow, Lewis & Wickenhoefer, made a thorough inspection of the building and supervised its remodeling in accordance with the suggestions of the committee in charge. Fortunately the floors were entirely supported by the main walls of the building, so that practically all of the partitions could be removed without weakening the construction. By the time the matter had reached its concrete form, it was realized from the extent of the epidemic that even with the use of every available foot of space the institution would be crowded to its utmost capacity. On this account, the plans were altered several times before final adoption, and some of the quarters provided, particularly those for the office force, are somewhat inconvenient. Nevertheless, all branches of the work have been developed

simultaneously, and one of the chief reasons for the efficiency of the institution is the cheerful cooperation of all those engaged in the work regardless of personal inconvenience.

The floor plans (Figs. 2 and 3) illustrating the paper give an excellent idea of the arrangement of the building and many of the details will be given later.

The organization of the institution comprises an administration department, a surgical department, an electrotherapeutic department, a depart-

ment of young student from a near-by institution sleeps in the building as a night watchman. To secure the best results in an institution of this kind, the duties of this administrative department and its relation to all the other departments must be very carefully defined and thoroughly understood.

II. SURGICAL DEPARTMENT

The surgical department consists of a visiting orthopedic surgeon, three attending orthopedic surgeons, a head nurse and three assistant nurses.

The visiting orthopedist is a man of large practice and wide experience, who gives a few hours a week more particularly in a consulting capacity.



Fig. 1. The Brooklyn office building which has been remodeled to furnish a hospital for the after-care of infantile paralysis.

ment of massage and muscle-training, a brace department, and a social service department.

I. ADMINISTRATIVE DEPARTMENT

The force of the administrative department consists of a woman superintendent, a janitor, a cleaner, a cook and a nursemaid. The work of this department covers the care of the building, buying of supplies for all departments, the keeping of inventories and auditing the bills, the supervision by the superintendent of janitor, cleaner, nursemaid and cook. On account of our lack of space no member of this force sleeps in the building, and all the laundry work is done outside. A



Figs. 2, 3. First (left) and second (right) floors of the building shown in Fig. 1, as remodeled by the architects, Messrs. Crow, Lewis & Wickenhoefer.

In order to secure efficiency, it was intended at the outset that a paid medical staff of men young enough to give a considerable part of their time, six days a week, should be secured. Later a part-time service with less remuneration was determined upon. We were exceptionally fortunate in our selection of this staff of orthopedic surgeons. All three have had excellent training and are enthusiastic workers. Their hours for the routine examination and reexamination of patients and the application of plaster and various forms of apparatus are from 2 to 4 p. m., but these are frequently prolonged by press of work. The operative work is performed in the mornings, beginning at 8 a. m., two or three times a week.

Although this hospital was established primarily for the care of victims of the recent epi-

demic, a small percentage of other orthopedic work has drifted in from time to time. A large room on the second floor of the building, suitably equipped with plaster sink tables and divided by washable curtains, is used for the examining and plaster room (Fig. 4).

A large room on the same floor with windows on three sides makes an ideal ward containing eight beds. Owing to the enormous amount of work entailed in the original examination and differentiation of the large number of cases applying during the first months of the work, the operating room did not come into use until late in February.

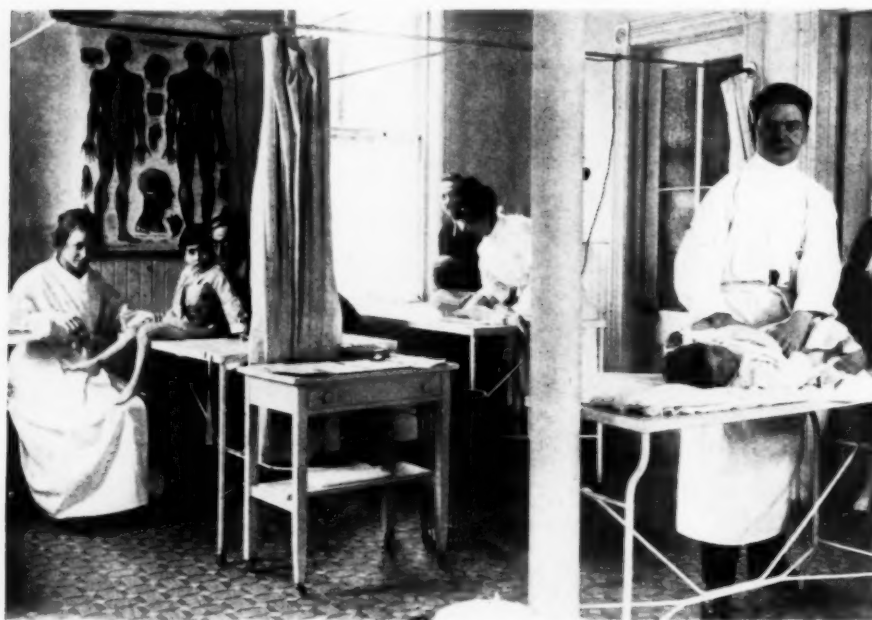


Fig. 4. Room equipped with plaster sink tables and divided by washable curtains, used for examining and plaster rooms.

During March nine operations were performed and during the first half of April there have been fourteen.

The operating room and a small room containing a sterilizer are located next to the ward.

III. ELECTROTHERAPEUTIC DEPARTMENT

This department is conducted by the services of a neurologist and part time of one of the nurses from the surgical department.

The use of electricity in poliomyelitis is considered useless by a very large number of orthopedists, but many neurologists are convinced that it has definite value. Although I was very skeptical when our institution was opened, it seemed best to make use of an agent that was endorsed by many observers. After consulting with some of the leading neurologists of New York City, we secured the services of a neurologist who had had wide experience with electricity during the epidemic of 1907 and who has given much of his

time to that kind of treatment for the past ten years. He receives the same remuneration as the two junior orthopedic surgeons and gives the same amount of time to the work.

IV. DEPARTMENT OF MASSAGE AND MUSCLE-TRAINING

The staff of the department of massage and muscle-training consists of a woman physician, three graduates in muscle-training, five masseuses, and one masseur.

This department is open continuously from 10 a. m. to 4 p. m. or later. The doctor in charge is on full time. Some of the other members of the force are on full time and some on half time, making a total of approximately thirty-three hours a day treatment.

As a preparation for massage and muscle-training, practically every child first receives from five to fifteen minutes in electric bakers constructed of canvas, heated by electric-light bulbs similar to those employed in hospitals to produce diaphoresis. The patient then receives muscle-training, followed by massage. The muscle-training is carried on very strictly along the lines laid down by Dr. Lovett; that is, the smooth metal tables and a plentiful supply of talcum powder are

employed for this work in all types of lateral and assisted movements. During cold weather the white enamel tables were too cold for comfort, but this trouble was obviated by the introduction of a number of electric-light bulbs underneath them to give the necessary warmth. In all this work, as well as in the preliminary examinations, large paper napkins are supplied for each individual patient to prevent the possibility of transmission of infection by vaginal or urethral discharge.

Even in 1840 Heine drew attention to the fact that the temperature of these paralyzed limbs was far below normal and that circulation was poor. This condition has been recognized by every writer on the subject since, but the practical relation of this fact to treatment has never been very generally appreciated. Nevertheless, it has a very important bearing upon the value of massage and muscle-training.

A spirited and at times acrimonious discussion has been carried on in New York for the past six

months in regard to the value of this kind of treatment and also as to the frequency with which the treatment should be given to secure the best results. That the treatment produces improvement aside from the return of function normally occurring soon after a recent infection is proved by the fact that we have been treating



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Fig. 5. Child with double lateral curvature, as a result of paralysis of the muscles of the back, in a suspensory apparatus, the same that is used for the application of plaster jackets, as a part of routine treatment for the purpose of stretching by gravity the contracted back muscles.

with remarkable success a number of cases of from two to nine years' duration in which there had been no appreciable improvement for a long time. Some orthopedists prescribe daily treatments, others do not. This institution was established with the belief that comparatively short treatments would give the best results and that it is quite easy in some cases at least to injure the patient both by overtiring the muscles and by a too active protein metabolism as to produce a high degree of acidosis. I have seen a typical acidosis with high fever, air hunger, vomiting and collapse appear so frequently in cases receiving indiscriminate treatment as to be absolutely convinced of the truth of this theory. Our statistics show, however, that there is little real danger of such an occurrence in an institution of this kind, as we have apparently averaged about seven treatments per child during the month of March.

V. BRACE DEPARTMENT

The brace department employs a force consisting of one brace-maker, one leather and canvas seamstress and one plaster-of-paris bandage-roller.

Originally it was intended to buy braces and all other forms of apparatus either from one of the large manufacturers or from some other institution conducting a brace shop. It was quickly realized, however, that the unprecedented demand for such articles in Greater New York would so delay the delivery as seriously to interfere with the success of this institution, and it was decided to establish a brace shop if room could be found for it.

Fortunately there was a dry, light cellar under the entire building, and about one-half of this floor



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Fig. 6. The brace-maker and his shop. The unprecedented demand for braces and other apparatus used in the treatment of infantile paralysis rendered it necessary to set up a shop within the hospital.

space, as shown in the plans, was divided off into two rooms to be used for this purpose. The larger room was equipped with an electric motor, lathe, bushing machine, bench, tools, and the latest type of gas forge with blower. We were successful in securing the services of an exceptionally expert brace-maker, and his full time is occupied in this work (Fig. 6). The smaller room is equipped with a heavy model electric driven sewing machine, tables, and supplies for bandage-rolling, leather-cutting, etc. Financially, as well as from the point of view of efficiency and convenience, the establishment of this department has proved to be a very wise undertaking.

VI. SOCIAL SERVICE DEPARTMENT

In the social service department are a head worker, an assistant worker, and a stenographer and typist. At the date of writing, we have enrolled for treatment in this institution over one thousand patients. To carry on even the most essential duties of social service for such a large group is a serious undertaking. The various cards

used for keeping track of the patients are illustrated in this article, and each family has a separate folder in the file and these folders are cross-indexed in various ways.

The head worker of this department was associated with the Central Committee on After-Care of Infantile Paralysis for some months before taking charge of our work, and was, therefore, thoroughly familiar with the problems that she would have to meet. One of her chief duties is to follow up the cases that do not return regularly for treatment. Their absence is indicated automatically in the file by means of a special card.

WORK ACCOMPLISHED

Since this hospital opened on October 7, 1916, there has been a steady growth in the amount of

work to be done. The most important statistics for the month of March, 1917, are as follows:

Visits and revisits to the orthopedic surgeons.....	619
Operations performed	9
Number of patients treated	501
Number of visits made	3,587
Number of electric treatments	1,835
Number of baker treatments	3,086
Massage and muscle-training.....	3,474

Total number of routine treatments.....8,395

COST

As our building is lent to us, it would be difficult to accurately estimate the primary cost of establishment.

Our pay-roll is a little over \$2,000 a month, with sundry expenses of about \$250.

THE WHITE OPERATING ROOM

Suggestion of Remedy for Its Defects—Beaked Caps and Amber-Tinted Glasses Used to Obviate Effect of Glare From White Walls

By WILLIAM LEE SECOR, M. D., A. M., F. A. C. S., CAPTAIN M. O. R. C., U. S. ARMY, KERRVILLE HOSPITAL-ON-THE GUADALUPE, KERRVILLE, TEX.

FOR years hospital architects endeavored to construct our operating rooms so as to admit just as much light as possible and from as many angles as possible. Circular rooms, octagon rooms, rooms with glass skylights, or even glass domes were constructed in an endeavor to reach the ideal which would provide an abundance of soft light from above and from every side. These operating rooms were lined with white walls of tile or enamel with white ceilings and floors, so that a high percentage of the light which entered the operating room was reflected from every surface.

During the past few years it has been suggested from several sources that our operating room walls should be colored or tinted gray, green, or even black, and that our sheets, towels and operating room furniture should be black or dark green, the reason given for the suggestion being that the glare of all white surroundings is detrimental to the vision of the surgeon and prevents him from obtaining as good a view as he might when working in deep cavities. The eye must accommodate to a large extent and rapidly to change from a view of the surroundings to a view of viscera lying deep in the abdomen or pelvis.

The point made by those who say that operating room glare is detrimental to the vision of the surgeon and prevents his best work is well taken, but the remedy suggested is far from ideal. There are two reasons for admitting sunlight to an oper-

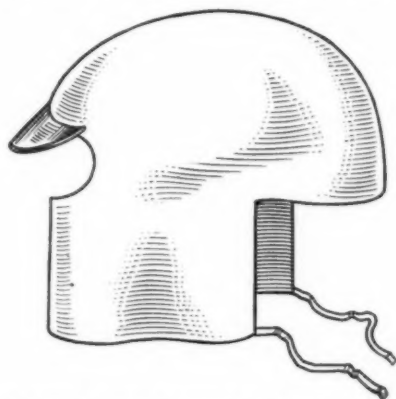
ating room; first, to illuminate it, and second, to sterilize it.

The illumination of a room depends upon two factors, the amount of light admitted to the room and the amount of light reflected from the surfaces it strikes within the room. After a study of the coefficient of reflection of various colors, H. A. Gardner published his results in the *Journal of the Franklin Institute* for January, 1916, and showed that the coefficient of reflection of white is 88 percent, of light green 42 percent, medium green 14 percent, and dark green 11 percent. What is the advantage of going to great expense to permit an abundance of light to enter an operating room through expensive ground glass windows if only from 11 to 42 percent of it is to be used and the rest absorbed by the surrounding surfaces?

About four years ago we solved this problem to our satisfaction, and, having used the solution continuously since that time with very gratifying results, desire to recommend it for your trial. We built an octagon operating room, the ceiling of which was carried to a point, giving the effect of eight triangular panels; four of the sides from tip of pointed ceiling to floor are of heavy ground glass, which admits an abundance of north light. The walls, furniture, etc., are all white; to obviate the effect of the glare we have used beaks on our caps, and on bright days large amber-tinted spectacles are worn. The beaks on the caps

shield the eyes nicely and add much to the comfort of the operator, while the amber-tinted spectacles not only increase the comfort and do away with the bad effects of glare, but also serve to protect the eyes of the operator from infection, which a search of the literature will show to be of considerable importance.

The cap we use is a modified Mayo cap with small beak, and, to make it cooler, the back part



Beaked operating cap for use in white operating room.

of the skirt is cut away. The beak is made of several thicknesses of muslin with a number of rows of machine stitching and does not in the least hinder sterilization.

To tint the walls of an operating room not only does violence to the esthetic and psychic effect of the pure white room, but makes it much more

difficult to keep the room clean and sterile. White will show up macroscopic dirt much better than colors and also makes it easier to rid the room of microscopic contamination, for the effect of strong light upon some of our most dreaded bacteria is well known.

In the wards and private rooms there is nothing more restful for the patients' eyes or more practical than light green ceilings dropped about four feet on the side walls with the lower part of the walls and woodwork done in cream enamel or washable flat tone.

There is no reason why the patients' rooms in the surgical department of a hospital should be tinted or frescoed, furnished in oak, walnut or mahogany, and provided with large rugs, pictures, and heavy draperies in an endeavor to make them homelike. This may be all right in the medical units, especially for nervous cases, those only slightly ill and those who spend a long time in the hospital.

The average surgical patient is only in the hospital for two or three weeks and the keynote of success in these cases is efficiency. I believe that more efficient service can be given in a room with plain white enameled walls and woodwork, composition floors with small washable rug, and high-class white enamel steel furniture throughout, than can be given in the highly decorated and draped rooms now being advocated by some.

THE NEW YORK CHILDREN'S EYE CLINICS

Work of the Bureau of Child Hygiene of the New York City Department of Health in Caring for the Eyes of School Children—Importance of the School Nurse—Prevalence of Contagious Eye Diseases

By WILLIAM MERLE D'AUBIGNE CARHART, M. D., OCULIST, BUREAU CHILD HYGIENE, DEPARTMENT HEALTH, NEW YORK

THERE are nine children's eye clinics in New York City maintained by the bureau of child hygiene of the municipal department of health. In these clinics all school children of any of the public or parochial schools are treated for eye diseases or fitted with proper glasses by a staff of competent specialists taken from the eligible lists of the municipal civil service. So extensive has this work in caring for the eyes of the city's school children become that an increase in the number of these clinics is urgently needed. Twenty-eight additional clinics for treating contagious eye diseases in the schools have been asked for and may possibly be provided next fall. Children can then be treated without the overcrowding and without the long journeys now inseparable from inadequate clinical facilities. Ulti-

mately there should be clinics established in nearly every large school, so that treatment of eye conditions may be carried out with the least possible interruption of school duties. As it is now, the usefulness of these clinics is often sadly hampered by the children failing to continue in attendance if the clinic in question is at such a distance from home and school as to make frequent visits to it practically impossible. It has been found that a mile is about as far as children can habitually walk to a clinic, and carfare is out of the question for many of those most needing prolonged treatment.

To give a rough idea of the extent of this work in child hygiene, I may say that some of these children's eye clinics treat as many as 150 to 200 children for sore eyes in one day during the rush

season when in fall and winter the work is at its height. One clinic in six months had 1,585 new cases of sore eyes, and, counting revisits in that clinic, over 12,000 treatments were given in the same period of six months. These children are picked out as needing treatment for their eyes by the medical school inspectors in their daily visits for the inspection of each school, and are brought or sent to the children's eye clinic nearest the school by the school nurse or parent, where they are treated by the oculist in charge of the clinic.

Those of them who are suffering from inflammation of the eyes in a contagious stage of the disease are excluded from school until all danger of infection is past, and such children are followed up by the school nurse so as to insure faithful attendance at the clinic until discharged as cured.

The procedure followed in these children's eye clinics can be briefly described as follows:

Each child on entering the clinic presents a card from the school nurse stating whether the child is sent for contagious eye disease or for correction of refractive errors with glasses. According as this card states, an admission clinic card and a history card are made out either for treatment of eye disease or for refraction. Both eye diseases and refraction are treated in the same clinic, but, so far as possible, refractive errors are corrected on alternate days with contagious eye disease treatment.

The limits of this article prevent a detailed description of the refraction work of our children's eye clinics, and so I am forced to confine the present article to the methods used to combat contagious eye diseases in the schools.

In addition to the registrar who keeps the records and is in charge of the administration of the clinic, there is in some clinics, and should be in all, a clinic nurse to assist the oculist in his treatments. These children respond very quickly to the intelligent care of a sympathetic clinic nurse, and the comparative success or failure of a children's eye clinic depends almost as much upon the excellence of the nurse as upon the professional ability of the oculist. Nearly all forms of eye disease in children are treated in these clinics, although contagious diseases of the lids, such as trachoma and pinkeye, are given particular attention. Some eye diseases requiring special facilities or operative treatment are necessarily referred to public or private hospitals or clinics in the vicinity. By arrangement recently made with the Otisville Sanatorium, children with tuberculous eye diseases can be sent out of town for expert care at that institution. As can be easily understood, the treatment at these children's eye clinics is necessarily confined to simple medical

treatment of the eyes, such as can be performed with the facilities furnished by the department of health and the department of education. Each child is treated in turn by the oculist, either daily or three times a week, as the case requires. Some children are given eye drops or collyria to use at home, although it has been found that many ignorant or careless children lose or throw away the bottles of medicine, and so we have come to depend almost exclusively upon treatment actually performed at the clinic by the oculist and clinic nurse.

Recently trachoma schools have been started where children afflicted with contagious trachoma can be isolated from other children and yet continue at their studies in special classes suited to their needs. In these schools intensive treatment for trachoma is carried out by a nurse in attendance all day, in addition to supervision and treatment by oculists who visit the schools as often as required. These trachoma schools seem to go far



Fig. 1. One of the eye clinics conducted in a public school by the New York City Department of Health.

toward solving the problem of treating severe contagious trachoma in an effective manner and at the same time allowing the child to continue his lessons in school. We have found it possible to accomplish a great deal of hygienic control and instruction by having the nurse in constant attendance, and children often improve much faster in these trachoma schools than in the regular children's eye clinics with little or no effective supervision or control. Intensive treatment repeated several times daily by a nurse properly trained in eye work and carefully supervised is much more effective than one routine treatment a day by an oculist or medical inspector, combined with the usual home disregard of medication ordered or instruction given. This phase of our work is worthy of more extended trial than it has yet been possible to obtain.

Trachoma is the most important of the contagious eye diseases treated in our children's eye clinics. In its various forms and phases, it is quite widely spread in all our schools, but nothing

like as prevalent as fifteen years ago, when the department of health began its trachoma crusade. In 1903 a preliminary inspection of one large school of over 3,000 school children disclosed over 700 cases of trachoma. Today that same school would give approximately 50 cases or less, all under treatment. Through systematic inspection in the schools and through treatment of the disease, when found, by oculists of experience and ability, trachoma is now practically under control in New York City. We have found that the virulence of the contagion of trachoma is largely removed by treatment of the disease along approved lines, and now we no longer exclude many trachoma cases from school if the children are faithful in attendance at the clinic. It is now only in cases in which there is a secretion of mucopus in the eyes or in which complications exist that we are forced at present to interrupt school duties to any great extent.

In one illustration I have shown a view of one of our children's eye clinics (Fig. 1), giving an idea of how the children are treated, and in an-



Fig. 2. Eye showing moderate development of trachoma.

other a view of the eyes of a child with trachoma (Fig. 2). The granulations of trachoma are the characteristic lesions of the disease, the removal of which by either medical or surgical means is the object of the treatment. Fortunately, the results of our fifteen-year crusade against trachoma have demonstrated that the disease can be controlled through faithful and scientific treatment by competent oculists in clinics equipped with adequate facilities. As these children usually become infected with this disease through the close associations of school life, there is an urgent moral motive for the establishment and extension of these children's eye clinics by municipal departments of health in close collaboration with the educational authorities. This beneficent work in

child hygiene requires for its complete success adequate financial support from municipal boards of estimate and the appointment of a staff of oculists of wide experience and thorough training.

Trachoma is a disease of the eyes liable to cause marked impairment of vision if improperly treated or neglected and, therefore, to entrust its care, without supervision by experts, to physicians in general practice, with little or no special knowledge or experience in diseases of the eye, is to risk permanent blindness in some of these children. The best is none too good for any child, and we should hesitate to inflict upon the child of the tenements a course of treatment by medical inspectors which we would refuse to tolerate for our own child.

In conclusion, let me say that these children's eye clinics of the New York City Department of Health have abundantly demonstrated their usefulness in controlling the spread of trachoma and in stamping out other contagious eye diseases in school children. The part of the work of the clinics in testing eyesight has not been touched upon in this article, but the removal of retardation in school from refractive errors has been an equally brilliant success of our bureau of child hygiene.

PUBLICITY IN HOSPITAL MATTERS

Do Not Seek to Hide What Needs to Be Cured—Newspapers May Be Your Strongest Allies

"Many hospital superintendents have jeopardized the support of their institutions by not according proper consideration to the newspaper representatives, seemingly trying to cover up things that the public should know," says Dr. M. Hotchkiss, writing of "The State Hospital—Its Purposes, Limitations, and Handicaps," in a recent number of the *Illinois Medical Journal*. "If there is a sore spot in your institution, the best way to do is to let the facts be known, if it is to be remedied. Go to your legislatures with demands for assistance; then, if it is not given, the blame is shifted, and one should feel at liberty and consider it a duty to give the public knowledge of the lack of assistance or help that should have been given. . . . Take your newspaper man to the worst of your place and tell him what you need to overcome the conditions, and nine times out of ten he will be only too anxious to help you out through the columns of his paper; but if you try to hide or cover up a condition that you are not proud of and the information is obtained from some disgruntled, discharged employee, the management is discredited. Show up the undesirable features of your institution, if you are not to blame for them yourself, and you will be able to remedy the condition by so doing. Give the public a chance to know of things directly from headquarters, and not through garbled statements. Ninety-eight percent of the adverse criticism of state institutions is due to ignorance, and it is sad to relate that less than two percent of commendation is given to balance the account."

MEDICINE AND METRICS

Saving of Time by the Use of a Decimal Basis for the Writing of Prescriptions— Danger in Hastily Written Apothecaries' Symbols—Death in the Minim Sign

BY H. V. ARNY, NEW YORK, CHAIRMAN OF THE METRIC COMMITTEE, AMERICAN CHEMICAL SOCIETY; CHAIRMAN OF THE COMMITTEE ON PUBLICITY, AMERICAN METRIC ASSOCIATION; MEMBER OF THE COMMITTEE ON REVISION OF THE UNITED STATES PHARMACOPEIA, 1910-1920

IT is unnecessary to speak to the medical profession about "the metric advance." In American medicine, as in American pharmacy and in American chemistry, the metric system has already arrived. In 1880 the metric spirit was strong enough in American medicine and pharmacy to induce the committee intrusted with the sixth edition of the United States Pharmacopeia to use, instead of the archaic apothecary weights, a compromise measure known as "parts of weights," this being placed on a decimal basis. In the seventh revision of the Pharmacopeia (U. S. P., 1890) metric weights and measures were used *in toto*, and, as the two subsequent editions are metric in character, we have had almost thirty years of metrics in medicine and pharmacy.

If metric units are not used today in prescription writing, the leaders of medicine and pharmacy are not to blame. The cause of the use of nonmetric units is rather to be sought in the inertia of the mass of practicing physicians, which leads them to stick to old customs rather than to learn new things.

Is it more convenient to write prescriptions in metric or in the ordinary U. S. units? That depends entirely on whether the prescription writer uses strictly metric doses and adjusts them to a decimal basis, or whether he sticks to the old doses in ordinary weights and measures, transposes them into metric equivalents, and then designs his prescription on a nondecimal scale.

Let us take up this phase of the question with genuine prescriptions before us. Herewith are presented four typical prescriptions: two (in metric quantities) written by a Hungarian physician (Fig. 1), one (in metric units) written by a German-American doctor, and one (in U. S. units) written by a physician of New York.

To compare these four is not easy, since it is obvious that the only fair comparison will be by studying the identical prescription in both systems, and therefore I have furnished under each a transposition of the prescription into the terms of the other system.

The first duty of a pharmacist, on receiving these prescriptions, would be to calculate the dosage of the last three pairs, the first pair, calling for a gargle, with no assigned dose, not coming within the scope of our present task.

Studying the second pair of prescriptions (Nos. 3 and 4), we are confronted by that interesting and perplexing problem, "What is a drop?" Un-

Dr. Haslinger J. J.
(*Belgyógyász és orvósz*)
Rendel 3-5-ig d. u.
Budapest, IV. k., Kalap-utca 8. I. em. 7.

Rp. Acet. carbol 0.50
Exsicc. alum. ust. 2.0
Pip. spirit aromat. 20.0
R. dentifric 400.0
Fr. mucosa 40.0
Inf. Targirime

5. Tinct. belladonna 2.0
5. Corros. mercuric chlorid. 0.02
Alcohol. fortit. 10.0
Inf. 7 cups every 3 hours
pross 9/15

Hungarian No. 230.

Fig. 1. Two Hungarian prescriptions (Prescriptions 1 and 3). Transposed into terms of ordinary American prescriptions, they would read:

Prescription 2.

Phenol	8 grains
Exsiccated alum	30 grains
Aromatic spirit	4 drams
Distilled water	14 ounces
Syrup of mulberries (or other flavor).....	1 ounce
Mix. Use as a gargle.	

Prescription 4.

Tincture of belladonna.....	40 minims
Corrosive mercuric chlorid.....	$\frac{1}{2}$ grain
Diluted alcohol, enough to make.....	$\frac{1}{2}$ ounce
Dose: 7 drops every three hours.	

9 TO 11 A. M. ONLY REG. NO. 4480

Name *Mr. Miller* Age *34* Sex *M*

Address *3435* Date *May 21/16*

R *Phenolphthalein*
℥ss
Tell boy's 6, 5
meas. pilul. q. s. f.
pilul. n° 30.
T. 1 pill after meals

Fig. 2. American metric prescription (Prescription 5). Recasting into ordinary U. S. units, this will be:

Phenolphthalein 15 grains
Ox gall 1½ drams
Make 30 pills.
Dose: 1 pill after meals.

PATIENT'S NAME RESIDENCE

R *348773*

8.5 *Strychnine Sulf. gr. 1.*
Sol. Cit. 3ii
L. Ferric Chlor. 3j
Quin Sulf. 3ss
Syrup 3ii
Aqua Gr. 3iv
Sp. 3j
in water
after meals.
M.S.

Fig. 3. Prescription of a New York physician (Prescription 7). Rewritten as a metric recipe, this is:

Prescription 8.

Strychnin sulphate 0.07 gm.
Potassium citrate 9.00 gm.
Tincture of ferric chlorid. 33.00 mls.
Quinine sulphate 2.00 gm.
Syrup 65.00 mls.
Water, enough to make 200.00 mls.
Dose: teaspoonful three times a day.

doubtedly the prescriber considered 7 drops as one-half mil. and based his quantities of the tincture of belladonna and the mercuric chloride on the hypothesis of twenty-five doses in the finished mixture. Since, however, according to Remington's "Practice of Pharmacy," there are 137 drops in a fluidram of the two fluids prescribed (the tincture and the diluted alcohol), the two prescriptions really call for about seventy-five 7-drop doses. Taking, however, twenty-five doses as more closely agreeing with the prescriber's intention, we find that the metric dosage is

Tincture of belladonna.... $2.00 \div 25 = 0.08$ mls.
Mercuric chloride $0.02 \div 25 = 0.0008$ gm.

The U. S. dosage of Prescription 4 is

Tincture of belladonna.. $40 \div 25 = 1\frac{2}{5}$ or $1\frac{3}{5}$ minims
Mercuric chloride..... $\frac{1}{5} \div 25 = \frac{1}{125}$ grain

If the more accurate idea of seventy-five doses is accepted, then the real dosage will be one-third of the quantities given above.

Now for the phenolphthalein-oxgall prescriptions (Nos. 5 and 6). The dosage calculation of No. 5 is

Phenolphthalein $1.000 \div 30 = 0.033$ gm.
Oxgall..... $6.000 \div 30 = 0.200$ gm.

On the other hand, the calculation of No. 6 requires the following figures:

Phenolphthalein $15 \div 30 = \frac{1}{2}$ grain
Oxgall $1\frac{1}{2} \times 60 = 90$. $90 \div 30 = 3$ grains

In figuring out the dosage of Prescription 7, we must know that 6 fluidounces mean 6×8 , or 48 teaspoonfuls. Then we will find the dosage is

Strychnine sulphate $1 \div 48 = \frac{1}{48}$ grain
Potassium citrate
 $2 \times 60 = 120$ grains. $120 \div 48 = 2\frac{1}{2}$ grains
Tincture of ferric chloride
1 ounce = 480 minims. $480 \div 48 = 10$ minims
Quinine sulphate
 $\frac{1}{2}$ dram = 30 grains. $30 \div 48 = \frac{5}{8}$ or $\frac{5}{8}$ grain

As to Prescription 8, a metric practitioner would not be apt to transcribe No. 7 as a 6-ounce (180-mil.) mixture, but would write it as we do, in terms of a 200-mil. (50-teaspoonful) mixture, in which case the dosage of the active ingredients would be:

Strychnine sulphate $0.07 \div 50 = 0.0014$ gm.
Potassium citrate..... $9.00 \div 50 = 0.18$ gm.
Tincture of ferric chloride... $33.00 \div 50 = 0.66$ mls.
Quinine sulphate $2.00 \div 50 = 0.04$ gm.

If the critical reader will sit down and time his calculation of the foregoing doses, he will be apt to find that, as written, the metric prescriptions given above offer but little advantage as time-savers over those written in nonmetric units. This is due to the fact that none of the original prescriptions were written on a strictly decimal basis. Moreover, the one directing 7-drop doses, for reasons stated above, defies accurate calculation of dosage.

Let us, therefore, see how these prescriptions should be written to make them truly decimal. Turning to the ninth edition of the United States Pharmacopeia, we find the following average doses given for the active drugs ordered in the prescriptions cited above:

	Old units	Metric units
Phenolphthalein	2½ grains	0.10 gm.
Extract of oxgall.	1½ grains	0.10 gm.
(Representing oxgall.)	12 grains	0.80 gm.)
Strychnine sulphate	¼ grain	0.0015 gm.
Potassium citrate	15 grains	1.00 gm.
Tincture of ferric chloride.	8 minims	0.5 mil.
Quinine sulphate.	1½ grains	0.10 gm.
Tincture of belladonna	12 minims	0.75 mil.
Corrosive mercuric chloride	½ grain	0.003 gm.

In Prescription 3 the misleading 7-drop dose should be raised to the more accurate teaspoonful dose, and the amounts of tincture of belladonna and of mercuric chloride prescribed in a single dose should be 0.1 mil. and 0.001 gm., respectively. Then, if twenty-five doses are desired, we would get a prescription reading:

Tincture of belladonna.	2/50 mls.
Corrosive mercuric chloride.	0/025 gm.
Aromatic elixir, enough to make. . . .	100/00 mls.

In Prescription 5, while the single dose of oxgall (0.5 gm.) is satisfactory, the single dose of phenolphthalein should be 0.05 gm. when the amended prescription would read:

Phenolphthalein	1/50 gm.
Oxgall	6/00 gm.
Make 30 pills.	

Prescription 8 can be made more simple by changing the quantities of potassium citrate and of tincture of ferric chloride to 10 gm. and 25 mls., respectively, thus writing the prescription as follows:

Strychnine sulphate	0/07 gm.
Potassium citrate	10/00 gm.
Tincture of ferric chloride.	25/00 mls.
Quinine sulphate	2/00 gm.
Syrup	65/00 mls.
Water, enough to make.	200/00 mls.

Dose: One teaspoonful three times a day.

To avoid uncertainty of dosage due to the varying size of domestic teaspoonfuls, the physician should insist on the use of a medicine glass graduated to teaspoonfuls of exactly 4 mls. each.

When adjusted to a decimal basis as planned by the originators of the system, metric units are as superior to our old weights and measures as our decimal currency is superior to the pounds, shillings, and pence which our English cousins are now planning to place on a decimal basis.

A striking feature of the time-saving qualities of the metric system is that presented in the March number of the *Science Monthly* (page 202), in which is reported an actual test made on two classes of third-year university students in

calculating ordinary commercial transactions—one set being in metric units and the other being exactly the same problems expressed in the old system of weights and measures. In the first test six metric problems were done by fourteen students in 171 minutes with 68 percent correct, while the six identical problems in old units took the fourteen students 227 minutes with only 62 percent correct. In the second test seven metric problems were done by sixteen students in 360 minutes with 72 percent correct, while the seven identical problems in old units took the sixteen students 579 minutes with only 65 percent correct. In short, a task taking the entire thirty students 531 minutes to work in metric units required 805 minutes when proposed in the old system of units.

Still more serious from the medical point of view is the danger arising from the use of the old system of weights and measures in writing prescriptions. There is no druggist of any experience who has not wondered more than once whether a quantity symbol written by a physician meant the ounce (℥) or the dram (ʒ). That there is danger lurking in the minim sign (℥) was shown by a fatality that occurred in a south-



Fig. 4. Transformation of the minim sign in the handwriting of a physician of large practice.

ern city some thirty years since. A physician of large practice and curious chirography gradually changed the writing of this minim sign as shown in Fig. 4. A certain prescription of his, reading as shown in Fig. 5, was taken to a druggist, who read it as "tincture of aconite, 6 drams, water enough to make one ounce." The patient died, and the druggist was convicted of involuntary manslaughter, was ruined in business in consequence, and finally committed suicide.

It might be immediately pointed out that, if metric quantities are employed, a flyspeck or other unintentional spot might be mistaken for the decimal point. This danger is eliminated by some practitioners by the use of a comma instead of a period as a sign of the decimal point (see Prescription 5). Equally effective is the use of a prescription blank ruled with a vertical line, as shown is the prescriptions printed above, in which it will also be noted that the word "mil." is used to express what we have hitherto called the cubic centimeter. This is following the precedents established by the 1914 edition of the British Pharmacopeia and by the new ninth revision of the United

States Pharmacopeia. The change was made because of the findings of the Bureau of Standards that the cube of one centimeter varies a trifle from the thousandth part of the standard liter. Hence, according to the officials of the bureau, a milliliter (abbreviated "mil.") is a more exact and is also a simpler term than is the cubic centimeter.

Fig. 5. A prescription which killed a patient and caused the druggist's suicide. What happened to the doctor who wrote the prescription the story does not tell.

As stated in the opening paragraph, it is scarcely necessary to use the phrase "the metric advance" as far as the medical profession is concerned, except possibly in urging all medical teachers to emphasize metric rather than old-

style doses. As American medicine has largely adopted the metric system, it will be gratifying to the members of the profession to learn that metrics are making a distinct advance in other callings. Nothing in late years has shown this more clearly than did the Metric Conference held in New York City last December, on which occasion delegates from engineering, chemical, and pharmaceutical associations, and from such business organizations as the National Wholesale Grocers' Association, the Philadelphia Commercial Museum, and the Philadelphia Bourse founded the American Metric Association.

The association has provided three classes of membership: individual members, with dues of not less than \$2 a year; firms, with dues of not less than \$5 a year; and associations, with dues of not less than \$10 a year.

The object of the American Metric Association is to conduct a campaign of education as a prelude to a campaign of legislation toward the placing of our 110,000,000 people on a commercial and scientific parity with the 437,000,000 people now using the metric system.

THE JAMES J. GRAY CLINIC IN ATLANTA, GA.

New Out-Patient Building of Medical Department of Emory University—Twelve Specialties Provided for Under One Roof—Three-Fourths of the Twenty-Five Thousand Patients Are Negroes

By C. C. HINTON, M. D., CHIEF OF CLINICS AND ASSOCIATE IN MEDICINE, ATLANTA MEDICAL COLLEGE, AND H. F. HENTZ, ARCHITECT, ATLANTA

AMONG the first needs of the medical department recognized by the trustees of Emory University, after taking over the Atlanta Medical College, was a separate and adequate building for the dispensary. Up to the present time, owing to lack of space and money, the dispensary quarters have been located in the basement of the main college building and in a few rooms that were available on higher floors of this building. The construction of the two new medical buildings on the university campus for the accommodation of the first two years in medicine opened the way for the utilization of the ground now in possession of the school in a more advantageous manner, and a gift of \$50,000 from Mr. James J. Gray, Jr., of Rockdale, Tenn., provided the greater part of the necessary funds for the construction of the out-patient clinic building. The building (Fig. 1) is now approaching completion, and should be ready to be opened for use about April 1, this year.

This building is located on Armstrong Street, just in the rear of the main building of the medical school, which faces on Butler Street, directly

opposite the city hospital, and within a quarter of a mile of the population center of the city. It will be connected with the main building by a closed corridor. The rear of the dispensary building is within about one hundred and sixty feet of the future teaching hospital of the school, the plans of which are in the hands of contractors at present. This will also be connected with the dispensary by a closed corridor.

The James J. Gray Clinic building, the floor plans of which are shown in the accompanying article by Mr. H. F. Hentz, of Hentz, Reid & Adler, architects, consists of a basement and four floors. Only the basement and the first two floors are to be used as examination and treatment rooms. The northeast end of the basement (Fig. 2) is entirely above ground, and the natural lighting is quite good. At this end are the rooms for pediatrics and orthopedics, including the orthopedic workshop and gymnasium. At the opposite end of the basement is the x-ray department. The central and anterior central portions of the basement are arranged as storage-rooms for drugs and for the dispensary records, the latter

being connected with the receiving office above by a stair and a small hand lift for the rapid handling of histories during dispensary hours. At the middle of the posterior central part of the building is the elevator shaft with the stairway winding around it.

The only street entrance leads to the first floor (Fig. 3). This opens into a vestibule, to the right of which is a second door opening into the reception-room for patients. The door on the left of the vestibule is a one-way door which, as it cannot be opened from the outside, forces the patients to enter in the proper direction. A brass rail in the reception-room prevents patients entering the main waiting-room without passing the record clerk and chief of clinics for registration and instruction. The main office is in the anterior central part of this floor, so that all parts of it



Fig. 1. James J. Gray Clinic, Emory University, Atlanta, Ga.

can be under the observation of the chief. The southwest end of this floor is devoted to surgery. There are separate rooms for dressing for both sexes and colors (white and negro) and a small operating-room for minor surgery and also the nurses' work-room and general sterilizing and supply-rooms. Additional supply-rooms are found on each floor. The east corner is occupied by five medical examining-rooms and a small clinical laboratory. Both surgery and medicine are grouped about inner corridors which can be used for history-taking. About the north corner are grouped the social-service office, a locker-room for the staff and the pharmacy, the last being directly to the right of the exit passage and on the opposite side of the admitting office from the reception-room so that the incoming and outgoing patients do not interfere with each other. Separate prescription windows are conducted for white and for negro patients. On the stair landing from this floor, behind the elevator shaft, is the door to the hospital corridor.

On the second floor (Fig. 4) are the rooms for the specialties not provided for in the basement.

About the south corner are grouped dermatology and genito-urinary diseases with their own laboratory. The west corner is occupied by a small operating-room to be shared by genito-urinary and gynecology, the two clinics always occurring at different periods. The gynecology and obstetrics rooms connect with the operating-room by



Fig. 2. Basement floor of James J. Gray Clinic, containing pediatric, orthopedic, and x-ray departments.

an inner corridor. The north quarter of this floor is occupied by ophthalmology and the east corner by otorhinolaryngology, the two clinics having a small operating-room between them. On the southeast and side between the corner and the elevator is the neurological clinic.

The third floor (Fig. 5) is to be used entirely

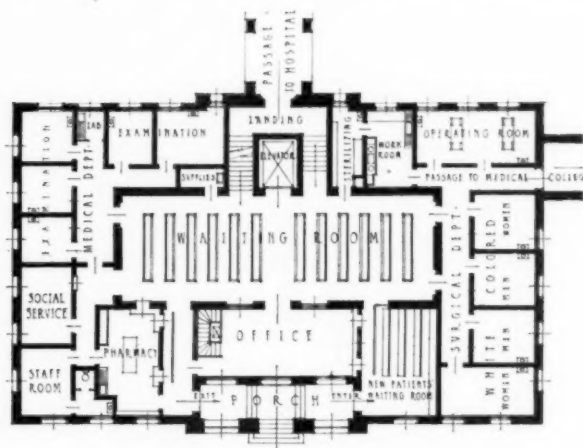


Fig. 3. First floor of James J. Gray Clinic, containing reception room, surgical department, medical examining rooms, etc.

as a dormitory for the interns of the future hospital and the senior students who are on duty for out-patient obstetrical calls.

The fourth floor (Fig. 6) is only a partial floor, consisting of a paddock for laboratory animals, an operating-room, a sterilizing-room, and the fan rooms.

The building has a very generous supply of windows and a large light-well extending down

to the first floor. Ventilation is by a fan system from the roof. Complete wiring is installed for a telephone system to all of the rooms.

The activities of the dispensary are divided into twelve departments: medicine, pediatrics, neurology, gastro-enterology and dermatology; surgery, gynecology, obstetrics, ophthalmology, otorhinolaryngology, orthopedics, and genito-

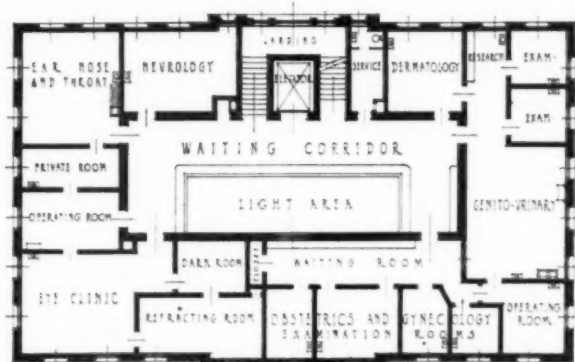


Fig. 4. Second floor of James J. Gray Clinic, containing dermatological, genitourinary, gynecological, obstetrical, otorhinolaryngological, and neurological departments.

urinary and venereal diseases. Besides these, there are the x-ray and cardiograph stations. The staff consists of 65 doctors, distributed as follows: medicine 10, pediatrics 5, neurology 4, gastro-enterology 1, dermatology 2; surgery 16, gynecology 6, obstetrics 3, ophthalmology 4, otorhinolaryngology 4, orthopedics 2, genito-urinary 8. All members of the staff are active teachers in

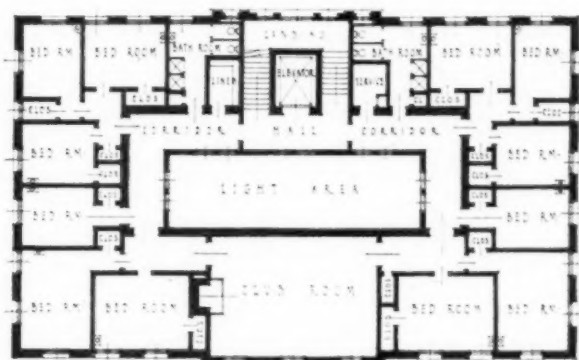


Fig. 5. Third (dormitory) floor of James J. Gray Clinic.

the medical school. The chief of the clinics holds a part-time salaried position at present. The pharmacist, record clerk, and two nurses have full-time positions.

The attendance of patients is over twenty-five thousand a year, of whom over six thousand are new admissions. About 25 percent of the patients are white.

CONSTRUCTION

The building is of reinforced concrete floor construction on brick bearing walls. The exterior is

of vitreous brick laid in Flemish bond, with trim and cornice of Indiana limestone. Each room (and each series of rooms) is ventilated by means of an exhaust fan, installed in a pent-house on the roof. The heating and plumbing pipes are run in chases cut in the wall, so that no pipes will be evident except as they are in direct connection with fixtures.

The floors, with the exception of those in operating-rooms, which are of white ceramic tile, and the office and dormitory floors, which are of rift yellow pine, are of cement, with an approved hardener used in the finished surface. All trim for doors throughout is of pressed steel. A sanitary base of pressed steel is installed throughout, except on the dormitory floors. The walls are of hard-finish plaster, painted with several coats of

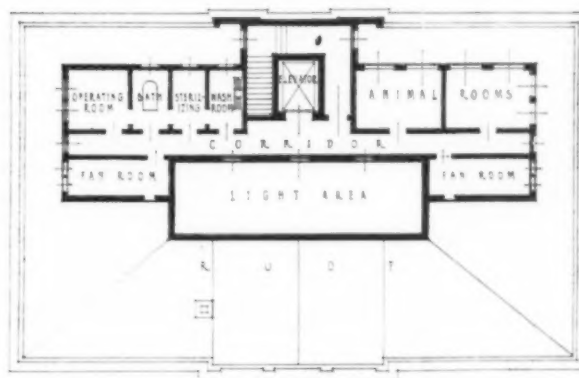


Fig. 6. Fourth floor of James J. Gray Clinic, containing animal room, etc.

oil paint; all doors are of birch, unpaneled. Each department is equipped with electricity for lighting and both electricity and gas for the equipment.

The entire plant, when completed, will consist of the present medical college building connected by passage-ways to both the out-patient building and the hospital, and these two in turn connected to the nurses' home. An inside court or garden is thus provided, which will serve not only as a valuable air space between the buildings, but also as a recreation ground for the interns, nurses, and convalescent patients.

Bequests of \$5,000 to the Episcopal Hospital and \$1,000 each to the Samaritan Hospital, Philadelphia Home for Incurables, Children's Hospital, and Sheltering Arms Hospital, all of Philadelphia, are included in the will of the late Harriet Shaw, of that city, recently probated.

Plans have been filed with the New York City Building Bureau for the Carson C. Peck Memorial Hospital to be erected in Brooklyn at a cost of \$240,000. The hospital will consist of a five-story main building, 180x41, with a separate structure for power plant, garage, etc. Mrs. Clara C. Peck, of Shrewsbury, N. J., is responsible for the new institution, it being her desire to establish a memorial to her husband, Carson C. Peck, who died in April, 1915.

STANDARDIZATION OF HOSPITALS—CLASSES II AND III, SEMIPUBLIC INSTITUTIONS

Hospitals Conducted by Boards of Trustees Elected by Subscribers and Associations, But Not Answerable to the Tax-Paying Public—High-Class Institutions With Rigid Requirements—Schedule for Marking—Details of Plan

By JOHN A. HORNSBY, M. D., CHICAGO, IN COLLABORATION WITH MISS MARY WHEELER, PRINCIPAL OF THE ILLINOIS TRAINING SCHOOL, CHICAGO; DR. SOLOMON STROUSE, FORMER PATHOLOGIST IN AND NOW MEMBER OF THE MEDICAL STAFF, MICHAEL REESE HOSPITAL, CHICAGO; MISS RENA S. ECKMAN, FORMER DIETITIAN, MASSACHUSETTS GENERAL HOSPITAL, NOW OF TEACHERS COLLEGE, COLUMBIA UNIVERSITY, NEW YORK; DR. J. T. CASE, ROENTGENOLOGIST, BATTLE CREEK, MICH.; DR. EDWARD S. BLAINE, ROENTGENOLOGIST, COOK COUNTY HOSPITAL, CHICAGO; MR. E. C. LARSON, FORMER ACCOUNTANT, NOW ASSISTANT SUPER-INTENDENT, MICHAEL REESE HOSPITAL, CHICAGO; MR. MICHAEL M. DAVIS, JR., DIRECTOR, BOSTON DISPENSARY, BOSTON, MASS.

A SEMIPUBLIC hospital is one conducted by a board of trustees elected by those who subscribe to the funds, and supported by private subscriptions and endowments and out of earnings from patients. These hospitals are usually controlled by enterprising and philanthropic citizens, in their private capacity, and are among the best institutions in this country. They usually have a considerable proportion of their accommodations devoted to private paying patients, and when well conducted they set apart a specific number of beds for free patients whose care is provided for out of funds specially appropriated for the purpose or out of surpluses after the ordinary running expenses are met.

The time has arrived in this hospital era when we are required to recognize some definite, fundamental business principles in the policies, purposes, and administration of our hospitals, and one of the most important factors in this recognition has to do with the care of free patients and the appropriations for that purpose. It is definitely understood that, in the semipublic hospital, supported by private funds and by endowments created by private gifts and bequests, the legitimate expenses of administration must first be met before charity, in the shape of free patients, is offered, and that the amount of this charity and the number of these free patients must depend entirely upon the amount of money left over after everyday charges of the institution are provided.

This month these semipublic hospitals are before us for consideration as Class II, meaning institutions of 250 beds or more; but there is no particular difference between the larger and the medium-sized hospitals of this class so far as their scientific and physical requirements are concerned except a difference of degree; hence we may suitably undertake to standardize the next class at the same time, that is, Class III, semipublic general hospitals, of 100 beds and up to 250.

It must be understood, of course, that we cannot expect that same elaborateness of architecture, installation, equipment and administra-

tion for the smaller institutions of this class that we have a right to expect of the larger. And in a final analysis there is not a great deal of difference between hospitals of this class and those institutions that we discussed last month; that is, the university or teaching hospitals, because today very many of these semipublic hospitals are also affiliated, either directly or indirectly, intimately or remotely, with medical schools, and whether this is so or not, there must be a training school in each of these institutions, staffs of medical men, interns, and a supporting public to be educated and trained along various lines, and, therefore, these institutions cannot escape the imperative necessity to consider themselves also as teaching institutions. The difference is that in Class I, the university hospitals, teaching is one of the primary purposes in the hospital, and all the facilities and equipment of the institution must be predicated on the attendance and training of undergraduate medical students. In the semipublic hospitals the attendance of students is usually merely an incident, where it is practiced at all, and it is not necessary to have large assembly rooms, laboratories of large areas, and the other essentials to teaching considerable groups of people, although even in this respect there is not so great a difference between the two classes of institutions as there was a time back, for the reason that medical faculties are finding it easier and better in every way to teach students in small groups rather than in large class bodies.

One main difference between the university and the semipublic hospital is that the heads of departments in the latter are not necessarily trained teachers, and these hospitals should not be demerited if their heads of departments are men and women who, though trained in their work, have not the gift or faculty of imparting information to others.

The schedule of marking which we presented last month for the university hospital will be continued throughout our classification because the items will be the same throughout and the same

allowances for the various departments can be considered quite the same throughout the whole of our standardization scheme and in all the classes of hospitals.

There is one essential difference between these semipublic hospitals and the university or teaching institutions, and that is that in the school hospitals we must mark the institutions on the basis of the dual purpose that the institutions are supposed to serve. To illustrate, a university hospital which had a good x-ray department in very small quarters, not large enough to admit groups of medical students, and at the head of the department a most excellent roentgenologist or operator who could not teach his branch of medicine, would be set low down in the marking; while precisely the same equipment and the same service in a semipublic hospital could well be marked high because the sole purpose of the department in the semipublic hospital is to make good x-ray plates and good fluoroscopic examinations and give deep treatments, under the orders of the patient's physician. The same factors must be considered in all the departments when we are making a survey of the semipublic hospital for standardization purposes.

It goes without saying that the hundred-bed semipublic hospital will not be forgiven if it is not equipped to do all the scientific work that may be expected of the large institution. In other words, the x-ray department of a hundred-bed hospital must be able to give to its medical men just as good kidney and gall-bladder and head plates, and roentgenograms of soft tissues, make just as good fluoroscopic examinations for diagnostic

purposes, and be able to do just as good treatment work, especially in the deep pelvis, as the larger institution. If it is not equipped to give this service, it must be marked down accordingly.

According to our view of it, the chief purpose of the standardization of hospitals is to show trustees, financial supporters, and those in authority over hospitals, just how far their individual institutions measure up to what may be expected of the best in that class; and one of the best results of this scheme of standardization will be to encourage trustees and financial supporters of hospitals to improve their architecture, equipment, and administration wherever they are shown to be weak. And we also feel that the scheme of standardization is to have its best results in the form of what we might call introspection; that is, the survey and marking of the institution by its own people. In the course of time, when this internal or self-examination has proceeded sufficiently far, we may then think about an evaluation of the hospitals by some authoritative body acting for the hospitals as a whole or acting on behalf of the public in the hospitals as a whole. This work was undertaken largely because of the hundreds—even thousands—of inquiries that have been constantly coming to THE MODERN HOSPITAL from administrators, trustees, and financial supporters of hospitals who wanted information concerning what might be expected of some particular institution in which they were interested.

We now follow with what we conceive to be a fair itemized schedule for the marking of a semipublic hospital of 100 beds or over, to cover Classes II and III:

MEDICAL STAFF:

Total percentage allowed, 40 percent.	20 percent.	Attendants: Personnel of staff..... Completeness of the scheme of organization..... Responsibility of the staff heads..... Simplicity of the organization..... Team-work, including coordination with administrative departments..... Original work, investigation, and publications.....		
	5 percent.	House staff: Personnel..... Plan of organization..... Discipline..... Team-work..... Number of interns per patient.....		
	15 percent.	Training school: Personnel of heads..... Personnel of pupils..... Preliminary requirements..... The curriculum..... The discipline..... Physical equipment, home, class rooms, apparatus, etc.		

LABORATORIES:

Total percentage allowed, 10 percent.	Comprehensiveness of scheme of organization.....		
	Personnel of director and associates.....		
	The scientific atmosphere of hospital under inspiration of laboratories.....		
	Physical equipment.....		
	Architectural arrangement of space.....		
	Original work and publications.....		

X-RAY DEPARTMENT:Total percentage allowed,
5 percent.

Comprehensiveness of the organization.....	.....	.....
Personnel—director and associates.....	.....	.....
Architectural arrangement of space.....	.....	.....
Equipment .....	.....	.....
Character of work done.....	.....	.....

DIETETIC DEPARTMENT:Total percentage allowed,
5 percent.

Scope of work.....	.....	.....
Personnel—director and associates.....	.....	.....
The general kitchen.....	.....	.....
The diet kitchen.....	.....	.....
Ward diet kitchens.....	.....	.....
Serving rooms .....	.....	.....
Dining rooms .....	.....	.....
Menu plans .....	.....	.....
Team-work with other departments.....	.....	.....

PHARMACY:Total percentage allowed,
5 percent.

Plan of the organization.....	.....	.....
Personnel—director and associates.....	.....	.....
Plan of distribution of medicines.....	.....	.....
Architectural arrangement, main drug rooms, floor cabinets, and scheme of transportation.....	.....	.....

DISPENSARY, OUT-PATIENT, ANDTotal percentage allowed,
5 percent.

SOCIAL SERVICE:		
Scope of work.....	.....	.....
Personnel—medical staff, director, and associates.....	.....	.....
Record-keeping system .....	.....	.....
Team-work with other departments.....	.....	.....
Architectural arrangement of space.....	.....	.....
Management and discipline.....	.....	.....

MEDICAL RECORDS AND ACCOUNTING:Total percentage allowed,
10 percent, divided be-
tween records and ac-
counting.

Comprehensiveness of plan as a whole.....	.....	.....
Completeness of plan of records for medical service.....	.....	.....
Simplicity of accounting system.....	.....	.....
Cohesion and cooperation between medical records and account- ing system .....	.....	.....
Value of medical records for purposes of statistics and literature	.....	.....

ARCHITECTURE, INCLUDING ALL PERMANENT INSTALLATION, SUCH AS PLUMBING, STEAM-FITTING, POWER PLANT, ELEVATORS, VENTILATION, VACUUM CLEANING, LAUNDRY, SEWAGE, AND GARBAGE DISPOSAL:Total percentage allowed,
5 percent.

Plan of the hospital as a whole.....	.....	.....
Execution of details .....	.....	.....
Taste and harmony of parts—ornamentation.....	.....	.....
Materials used in the building.....	.....	.....
Materials employed in permanent installation.....	.....	.....
Plans of arrangement of operating suite, kitchens and auxili- aries, laundry, etc. ....	.....	.....
Economy of operation permissible.....	.....	.....

EQUIPMENT—MEDICAL, SURGICAL, AND PHYSICAL:Total percentage allowed,
5 percent.

Completeness of regular surgical apparatus and furnishings in operating and dressing rooms.....	.....	.....
Special apparatus for doing unusual technical operations— splints, water and air beds, hoists, pulleys, extension appa- ratus; made-up boxes for special operations, such as venesection, spinal puncture, etc. ....	.....	.....
The furniture of the hospital—all departments.....	.....	.....

MANAGEMENT:Total percentage allowed,
5 percent.

Scheme of organization, for cooperation of scientific with do- mestic departments .....	.....	.....
Personnel—superintendent and department heads.....	.....	.....
General scheme for handling the public.....	.....	.....
General scheme for handling the staff.....	.....	.....
General scheme for handling the patients.....	.....	.....
General scheme for handling the trades people.....	.....	.....
General scheme for handling the employees.....	.....	.....
Arrangements for housing help necessary to be kept on premises	.....	.....
Cleanliness and order in the hospital.....	.....	.....
Training and discipline of the help.....	.....	.....

The future of mental hygiene work for public health nurses cannot be predicted. Dr. M. S. Gregory, Resident Alienist at Bellevue Hospital, sounded a significant note at the Mental Hygiene Congress in New York. He said, "Of course, certain forms of mental trouble should be treated in the state hospital. However, the more I think of the matter, and as my experience increases, the more I realize that for some classes of mental diseases hospital treatment may not be the best kind of treatment. These patients become, so to speak, institutionalized. The quiet

and routine life of an institution tends to the development of unhealthy physical and mental habits, and as life in an institution is so different from the outside world, they are unable to adjust themselves after their discharge. It would be more logical and profitable to treat such patients under normal and natural surroundings at home. I think the old Scotch method, as well as that applied in Gheel, Belgium, with added intelligent social service supervision, is preferable to state hospital care in certain types of mental disease."—Mary S. Gardner, "Public Health Nursing."

GREAT MEETING TO STANDARDIZE HOSPITALS

American College of Surgeons Calls Meeting of Experts to Chicago to Plan Ten-Year Campaign for Which Vast Sum Is Provided

On October 19 and 20 there is to be held in Chicago a most important meeting of members of the American College of Surgeons to discuss methods for working out a scheme of standardization of the hospitals on this continent. Besides 350 Fellows of the college who will participate in this meeting, prominent people are to be invited from allied walks of life, medical men as distinct from surgeons, leaders in the nursing thought of the country, specialists in laboratory work and in roentgenology.

There is to be a two-day session, to be followed, on October 22, by the meeting of the Clinical Congress of Surgeons of North America.

At the hospital standardization meeting the subject is to be divided into three parts:

1. What is the status of the hospitals at the present time? This part of the subject will be treated by practical students in hospital work.
2. What is next to be done to make the hospitals efficient from the standpoint of modern medicine? This part of the subject is to be treated by clinicians working in the hospitals.
3. How is the work to be accomplished?

As a result of this meeting the American College is to begin a ten-year study of the problem of standardization, and it is contemplated that an expenditure of approximately \$40,000 will be required the first year, and \$500,000, contributed by Fellows of the college, is behind the investigation. It seems there is no question about plenty of money to make the study all that the best thinkers of the country can suggest.

This meeting is inspired by and will be held under the direction of Dr. John G. Bowman, director of the American College of Surgeons, and the meeting will be presided over by Dr. Franklin H. Martin, president of the General Medical Board of the Advisory Commission of the Council of National Defense, and general secretary of the American College of Surgeons.

STANDARDIZATION OF HOSPITAL MORBIDITY STATISTICS

Confusion in the Situation at Present—Need for a Federal Voluntary Registration Area—Tabulating the Data

Failure must be the result of any attempt to compare hospital results and community fatality rates for the same diseases and conditions, says E. W. Kopf, assistant statistician for the Metropolitan Life Insurance Company in the Public Health Reports of the United States Public Health Service for June 15, 1917. This is because of the lack of uniformity in hospital statistics. Even in different departments of the same hospital, different systems of nomenclature and tabulation may be employed. In the University Hospital of Philadelphia, for instance, it is impossible to determine the complete experience of the institution with respect to any disease; and similar conditions exist in other hospitals and other large cities of the United States. The result is that it is impossible to gauge with any degree of accuracy just what hospitals accomplish as a public health measure.

The proper preparation of hospital statistics, Mr. Kopf believes, is a necessary step toward the continuous and complete registration of all serious sickness as a public health measure. To this end he recommends the establish-


ment of a Federal voluntary area. For this it would be necessary merely for a sufficient number of representative general and special hospitals (a) to adopt in common a nomenclature and classification, and (b) to transmit to a central Federal agency detailed tabulations of their sickness experience on a set of uniform reporting schedules.

The Bellevue and Allied Hospitals' nomenclature of diseases is the one at present most in favor for hospital use. Kopf suggests the construction of a standard manual for American hospitals, employing as a basis not only the Bellevue nomenclature, but also the forthcoming report of the United States Public Health Service Board of Nomenclature, the United States Public Health Service tentative nomenclature of diseases and conditions, and of parasites and parasitic diseases, the United States Navy classification of injuries, the nosologic system of the International Commission for the Unification of the Medical Statistics of Armies (Berlin agreement, 1907), the International Association of Industrial Accident Boards and Commissions' classification of injuries (by location, nature, and extent of injury and degree of disability), and the International List of Causes of Death as used by the Census Bureau, the United States Army, Massachusetts General Hospital, and Bellevue Hospital.

"The practical working of an approved system of nomenclature and classification in a group of representative hospitals," says Mr. Kopf, "will benefit the hospitals themselves by eliminating much of the present confusion over record filing and finding. Physicians trained in these hospitals will go into private and other practice with an adequate conception of the urgency of consistency in the use of medical terms. This will favorably affect the vital statistics prepared from the birth, death, and sickness reports by these physicians later on in general practice."

In scheduling the data, Mr. Kopf warns against failure through emphasis at the outset on relatively unimportant statistical detail. He suggests the use of a schedule plan which was eminently successful in England during the early 1860's. This successful English experiment recognizes seven "primary tabulation elements," as follows: (1) patients remaining in hospital on the first day of the year; (2) patients admitted during the year; (3) patients discharged as "recovered," "improved," or "relieved" during the year; (4) patients discharged as "incurable," "dying," "unrelieved," for irregularities, or at own request; (5) patients who have died during the year; (6) patients remaining in hospital on the last day of the year; (7) mean duration of cases in days and fractions of a day. Each of these "elements," Mr. Kopf says, could be presented as a table, duly classified in the stub or left-hand side of the table by disease or condition according to the accepted nomenclature, and by sex and age period in the box headings at the top of the table. Two copies of these primary tabulation schedules might be prepared by each hospital, one for transmission to the central Federal agency and the other for the preparation of the hospital's own report to its board of trustees or managers.

Such statistics, the author remarks, would afford, for the first time in America, some foundation for a comparative study of hospital results—the relative efficiency of the several types of general hospitals, of systems of nursing, and of modes of treatment. Such questions as the effect of an improvement in hospital results for pneumonia on the death rate and the effect of a decline in hospital puerperal sepsis, etc., on maternal mortality in the community can be answered only by the aid of statistics of general hospital experience.



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The Hospitals Are Gravely Threatened

Two topics are coming up at the Cleveland convention of the American Hospital Association, either one of which would justify the attendance of all the hospital people in this country even if there were nothing else on the program. These problems are the following:

The prices of everything that hospitals use have gone up out of all reason, and unless something is done about it many commodities are going up to entirely prohibitive points. Up to the time that this country went into the war on the side of the allies, the United States was furnishing hospital products of every sort to the allies and to our own army in peace time, leaving barely enough, at extremely high prices, for our civilian hospitals. Now the demands of our war department in the creation and maintenance of a vast army are drawing on these sources of supply to a point where the very existence of the civilian hospitals is at stake. The government is utilizing every agency and every influence that it can command to provide for its armies, and in that provision nothing has as yet been done to guard or guarantee the continuance of supplies for the civil hospitals. A resolution will be introduced at the Cleveland meeting for the appointment of a committee that shall bear a petition to the government authorities at Washington appealing for the inclusion of the

civil hospitals of the country in any control of commodities for the army and navy.

There is every reason to expect that such a petition will meet with a sympathetic reception in Washington, because the government has been asking civil hospitals to mobilize themselves and to prepare for all eventualities in the war. These hospitals have been drawn on for staff members, interns, and nurses, and the government is expecting that the hospitals will provide space for the care of sick and injured soldiers. If this is to be the case, it is reasonable to expect that the government will place the civil hospitals on the same plane with itself when it comes to commodities.

The other vital problem that will be presented at Cleveland is that concerning interns. The diminution in the number of medical schools during the past five years has brought the intern problem already to a critical stage; many hospitals are having to do without interns, and many others are being compelled to pay salaries out of all proportion to the service for the few men they are enabled to obtain. Now, then, the government comes along and calls many of these interns into the Medical Reserve Corps of the Army and is sending them abroad for service in the war, and thousands of others are being drafted in the great national army that is now being raised.

Great Britain took many hundreds of medical students out of the schools and sent them into her expeditionary army when the war broke out, and sent many hundreds of hospital interns into base hospitals and ambulance companies and to the front. Now Great Britain is suffering from a tremendous dearth of physicians, and the United States is just now asked to send three thousand qualified medical men to take care of the civil population of Great Britain because the men left behind constitute only one out of six thousand population; in this country we average one doctor to five hundred people.

It is understood the Surgeon-General of the Army realizes the shortsightedness of this policy and hopes to obviate the same conditions in this country; but, unless action is taken by the hospitals themselves, it is entirely probable that nothing will be done about it and that medical students will be drawn for the army and the hospitals depleted of their interns, and no provision made for this much-needed force in the civil hospitals of this country.

A resolution is to be offered in Cleveland providing for a committee to wait on the Surgeon-General of the Army and the Surgeon-General of the Navy and appeal for a change in the regulations so that medical students can continue with their school work and so that interns will not be

taken for the war, at least until the need is far greater than now.

If the President accedes to this appeal (for in the last analysis the President must make such change in the regulations) another regulation will have to be made providing for the acceptance in the Medical Reserve Corps of men over 55 years of age, as the figure now stands, in order that these older men may do the work back at home and release the younger members of the profession for the more active work at the front.

In past years, trustees and hospital superintendents have been entirely too indifferent about representation at the meetings of the American Hospital Association. Their best interests have suffered many times. The matter now concerns their very existence, and in self-defense every hospital in this country should send a representative to Cleveland to demand of the government proper protection for our civil institutions in the matter both of personnel and of purchasable commodities.

Hospitals to Standardize Themselves

This month we are publishing the schedule for the standardization of semipublic hospitals, large and medium-sized. Last month we had the university or teaching hospital; next month we shall have the small semipublic hospitals and community institutions.

A group of people well trained for the work have given mature consideration to a plan for arriving at some definite comparable standards for the hospitals of this country; hospitals have been classified, and these schedules are now in course of publication, and this publication will continue from month to month until every hospital in this country of every size and character has been included.

Now, what is to be done about the preliminary work? Are we to just look it over and forget it, or are we to apply it in our own institutions, each administrator and board of trustees within their own hospital? Certainly numbers of trustees and administrators ought to take this schedule and at least standardize or mark their own institutions, justly, rigidly, and conscientiously—not for publicity purposes, but in order that they may at least have the judgment of others as to the sufficiency of the work they are doing in their several departments. We have felt for a long time that the best effect of any scheme of standardization must come from an introspection by each hospital on its own account. If this is done in the right spirit, the standards of the hospitals of this country will be raised many fold and without the injection of any outside influences whatever.

In order that these schedules now in course of publication may be utilized to best advantage, we are this month changing somewhat the form in which they are presented and are providing columns in the published schedule for the markings.

We wish very much that the university or teaching hospitals would conscientiously mark themselves, using the schedule in our July number, and send us a copy of these markings with whatever comments they choose to make and whatever explanations their markings require. And we wish also that the large and medium-sized semipublic hospitals defined in this number would do the same for their institutions and send us a copy of the result, also with whatever explanations they may wish to make concerning the marks that they have given and with whatever details they wish to accompany these marks, as showing the basis upon which they have arrived at their conclusions.

If this is done we shall be able to help very materially in the work of standardization in the various hospitals and the discussion that must grow out of any such serious attempt to study our hospital problems must be of infinite benefit to all of them. The administrators of those hospitals that fall within the schedules that are published this month, or that were published last month, will confer a very great favor on all the hospitals if, just as soon as the September number reaches them, they will attend to this matter, mark their hospitals, and send us the copies of the sheets. These sheets will not be for publication, but for intensive study between the group undertaking this work and the hospitals in which the standardization is being done.

Another Feature of Wise Preparedness

We are beginning now in this country to think about wounds and disease in connection with the war. The offices of the War and Navy Departments have been thinking about these things for years, and it should be satisfying for the people to know that so much has been done in the way of preventive medicine as preparation for this great war that is upon us.

In the Mexican War six men died for every one who was killed. In the Crimean War France lost ten men for every one who was killed in battle. Our own Civil War made a record; only two men died from disease to every one who was killed. But during the Franco-Prussian War Germany made a record of another sort, losing twelve men by disease for every one who was killed. The Russo-Japanese War was the first war in history in which disease played a minor part as against

the tragedy of powder and shell, two men being killed for every one who died of disease.

But this great European war, so far as the United States is concerned, is to be epoch-making, and is to write new history in regard to the human salvage—if those who are responsible for our preparedness have anything to say about it.

We are now raising an army of approximately a million men. Not only are these men being selected carefully and by medical boards made up of the best material we have in the American medical profession, but other preparedness measures have been taken. Today all over this country the men subject to the draft and the men of the national guard, in course of transfer over to the federal service, are being examined not alone by the ordinary medical boards, made up in the ordinary way, but by corps of experts in almost every branch of medicine, who are sifting the men for the new national army to the finest mesh. There are tuberculosis experts, experts on heart diseases, eye, ear, nose, and throat men, and experts on genito-urinary diseases and other branches, all following up the work of the general medical boards and eliminating the weak and diseased and the incipient cases of disease even after the ordinary medical boards have accepted men for service. The new national army that goes to France, thanks to preventive medicine and astuteness and preparedness and the study of those in authority in the War and Navy Departments, will be the best body of men, physically, mentally, and morally, that has ever been turned out in uniform. What all this will mean cannot possibly be conceived by the ordinary mind at the present moment. It will certainly mean not only a far more efficient soldier body, capable of rendering a high order of service to the country, but also the saving of hundreds of millions—even billions—of dollars to the country in pensions that will not have to be paid because of this careful selection. Pensions are being paid for the Civil War in millions annually today; pensions are being paid even for the Mexican War that occurred away back in 1848, and pensions will be paid by the government for the war that we are now embarking on for the next seventy-five years. Who can say what it will mean in the saving of pensions that our trained officers of the fighting departments of the government have had the foresight to weed out and pick men free from any taint or suspicion of pronounced or even incipient disease?

While we are blaming Congress and our government for unpreparedness, let us make this exception: that the medical bureaus of the departments of war and the navy were vastly more than prepared; they were so far ahead of the unseeing and

unrealizing public and the by no means well-informed Congress that their motives and their methods and their alertness are not even now realized.

Divided Authority in Hospital Administration

Two cities in this country are in the throes of an agitation concerning the administration of their big, fine city hospitals; one of these is Los Angeles, Cal., and the other Kansas City, Mo. In Los Angeles a new superintendent of charities has been appointed in the person of Mr. Norman R. Martin, who has announced that the Los Angeles County Hospital, with a capacity of 1,400 patients, is to have a dual management, the buying and management being under a business head and the medical work under a physician or group of physicians. In Kansas City the physical departments of the Kansas City General Hospital are to be under a business manager and the medical work is to be conducted under the auspices of a committee of physicians.

In both these instances the authorities who have instituted these new systems are untrained in hospital work and wholly inexperienced. Mr. Martin seems to be an ambitious, energetic business man whose training has consisted, according to his own report, of a zigzag trip across the state of California, during which he traveled about 8,000 miles. Mr. Martin came back home thoroughly imbued with the idea that a dual management was the ideal thing for a great public hospital. Of course, we don't know where he got his information, but we are quite sure that Mr. Martin will regret the step he is about to take. Dual management of hospitals has been a failure in this country always. Many of our best institutions have tried it and have come back again to the "one-man power" and one-man responsibility.

The Kansas City situation seems to be almost hopeless. The doctors there are quarreling among themselves; petty politicians are after the spoils, and this latest move seems to be almost a concession on the part of the doctors that the politicians are to have the physical management of the institution with all that implies in the way of purchasing and the employment of people, while the physicians are to take over the treatment of patients through their medical committee—which means nothing at all, because the business manager, having the purse strings and the approval of the hospital board, can do as he pleases and give to the physicians what he thinks they ought to have and nothing more.

It is obvious why dual management of a hospital is out of the question. The treatment of patients involves the purchase of equipment, changes

in architectural arrangement, sometimes the employment of trained people, and the institution of a scientific technic in the institution throughout. The business manager has no conception, as a rule, of the fundamental purposes for which the modern hospital is conducted and he, taking the average business manager that we know, about believes that his buying and his conservation of funds and his evaluation of employees are the primary things in the hospital's management. As a matter of fact, all these things are merely incidental to the care of the sick, and the doctors have charge of that. The business manager, not at all informed as to the value of a thing, is more than likely to refuse to buy an expensive piece of apparatus or equipment on the ground that the institution cannot afford it; he thereby makes a reputation for economy with his lay board of managers, usually themselves politicians. So the hospital goes without things that the doctors need. Eventually the doctors cease to struggle over this condition; the next step is that they cease to be interested in the hospital, the patients suffer, and the politicians wax fat.

It seems inconceivable that a nation of business people like this, and at a time when business methods and business systems are the vogue, should commit the care of their sick, especially their dependent sick, most of whom are ignorant and all of whom are more or less helpless, to the haphazard whims and fads of people who, however enthusiastic they may be, know absolutely nothing of the underlying principles involved in their new-found employment.

The Labor Turnover in Hospitals

In these days of war economy, when hospital executives are anxiously scanning their budgets for every possible clue to reduction in expenses, we have so far seen no discussion of one item which has an important bearing on the payroll. The labor budget, indeed, has probably been one of the first to receive rigorous pruning in most institutions, and many superintendents no doubt feel that, if they are not paying extravagant wages or allowing their employees to waste time, they have made all the savings possible in the labor department. Yet, even so, it may be worth while to look for a leak right there.

What is your labor turnover? In other words, what proportion of your employees do you "hire and fire" during the year? If the proportion is large, have you ever stopped to consider what it costs you? Employers in the general industrial field are just beginning to find out that "hiring and firing" is an expensive process. Among the

elements of cost are the time of superiors taken up in instructing and supervising the green hand, increased wear and tear on implements, reduced amount of work during early period of employment, and increased amount of spoiled work by new employees. The cost of hiring a new factory hand has been placed at \$35 as a minimum and \$100 as a maximum.

In many cases it would doubtless be very difficult to estimate the cost of a high labor turnover in the hospital. Yet it would be rash to conclude that this cost is negligible. On the contrary, the success of a hospital, which depends on so many more intangible factors than that of an industrial establishment, may be endangered more than you realize by the rudeness, the indifference, or the stupidity of raw employees in low-grade positions. The indirect cost may far outbalance the direct cost, and the latter may be much higher than has been realized.

Mr. C. S. Rossy, psychiatrist at Sing Sing Prison, in an article published elsewhere in this issue, suggests that much of the high labor turnover in industry may be due to the employment of unsuspected high-grade morons. The suggestion may be worth heeding. Mr. Rossy has elsewhere¹ reported the finding of normal mentality in only 63 percent of the candidates for employment at the Boston Psychopathic Hospital. Since the lower grades of hospital employment are likely to be sought by failures in other walks of life, it would seem wise to exercise greater care, rather than less, in selecting employees for these positions.

Make Room for More Patients

At the outbreak of the European war, there were about 600,000 hospital beds in the United States and hardly any that were not needed. Many hospitals were crowded and some were compelled to turn patients away. During the last three years there has been a marked increase in the number of people going to hospitals for treatment in preference to remaining at home. It is true that many new hospitals have been opened and many existing hospitals enlarged, but the increased cost of building which has resulted from the war has checked this expansion to some extent. We know perfectly well that our hospitals are going to have to take immense numbers of sick people because of the war.

Medical men are being drawn on by thousands for war service, and, if our experience follows

¹Rossy, C. S.: Yerkes-Bridges Point Scale as Applied to Candidates for employment at the Psychopathic Hospital. *Boston Med. and Sur. Jour.*, 1916, CLXXV, No. 23; abstr. in *The Modern Hospital*, 1917, VIII, No. 1.

that of the European nations at war, the civilian medical profession is going to be depleted to such a point that every minute and hour and every visit must be saved if all the sick are to have proper care. American nurses are also being drawn on by thousands for war work, and the nursing field is being depleted to a point of even actual stress already. If this means anything, it means that vast numbers of the sick who have been kept in their homes heretofore must now be taken to hospitals where the time of doctors and nurses can be saved.

How are we to do this if all our hospital beds are full already? It seems to us the only way is for the hospitals to make extra room, and they can do this by removing well people from many of their hospital spaces. A hospital has no business, under any circumstances, to house well people, excepting interns. The superintendent should not be housed in a hospital, but should be permitted to live outside, where at least a small part of his time he may be free from the cares and anxieties and direct contact with the sick, and all other well people should live outside, for the same reason and for the additional reason that unoccupied well people about a hospital are a nuisance and are sure to get in mischief.

We have seen nurses' homes where housekeepers and dietitians and many other women assistants are housed, and this, too, in nurses' homes where there is not nearly room enough to house the number of nurses the institution needs. We have seen hospital units that were not yet "open" occupied by the help even while the rest of the hospital was crowded to overflowing.

A hospital today costs about 40 cents per cubic foot to build and equip. A private residence costs about 15 cents, and yet we are permitting well people, often the common help, to occupy space that costs 40 cents per cubic foot when they might well be housed in flat buildings or in private residence property. We can easily see that a seven-room flat, for instance, worth \$3,000 or \$4,000, could be made to house six or seven people, and such a flat could be rented for from \$25 to \$40 per month, whereas one private room in the hospital brings in an income of \$25 per week and upward.

If necessary, even nurses' homes could be made available for patients at a pinch and the nurses moved into flat buildings and other inexpensive places not suitably arranged for the care of patients, but entirely suitable for living places and young women for a time.

Before this war is over it is entirely probable that wooden shacks and even canvas tents will

have to be hurriedly constructed at many points to take care of the sick and hurt; we had better begin in a rational way before we are compelled to do so hurriedly and without adequate preparation.

The Buying Problem in War Time

Some months ago we had an editorial in these columns on "The Superintendent and the Salesman." That was followed a little later with another article on "The Salesman's Relations to the Institution and His Relations to His Home House." It seems now necessary to say something more on this general topic of salesmen who come in contact with the hospitals.

The war has called into active service under the colors many thousands of the most active and ambitious men in the country. Among these we can safely count the average salesman of merchandise, and so many of these men have gone to serve the country in the uniform that, without any question whatever, commercial houses are going to find themselves very short of traveling men until peace comes.

The hospitals have a duty to perform in this matter, and if they perform that duty they will get better goods and save themselves money. THE MODERN HOSPITAL has advised many large, staple commercial houses, handling hospital products, that the hospitals should and will be willing to transact as much of their business as possible by mail, and we fervently wish that this might come to pass. When a hospital is dealing with a house of good repute and proved integrity, that hospital should be entirely safe in buying from that house without the intervention of a traveling salesman, and we may say that most houses selling to the hospitals have made arrangements in their home offices to increase the efficiency of their people so that they may be enabled to attend to the wants of customers, especially institution customers, directly and by correspondence. In most of these houses, also, an arrangement has been effected with their salesmen by which the salesman who has been representing them in the hospitals may be credited with the sales that come in directly, although the salesman himself may be in France or on some other active service for the war.

Considering all these things, we very strongly advise the hospitals to continue their relations with the commercial houses that they have known and patronized for years, and to do their business by correspondence and by express and freight instead of relying on the personal intervention and personal attention even of a salesman whom they have long ago learned to lean upon and trust.

AMERICAN HOSPITAL ASSOCIATION MEETING AT CLEVELAND

Annual Conference of Hospital Workers Takes Place at Most Critical Period of Country's History—Hospitals Face Grave Responsibilities—The Program and High Lights of the City Itself

When the committee on time and place of the next meeting named Cleveland, Ohio, there was a reason. Cleveland is probably ahead of the rest of the country in social welfare and in the care of the public health. The organization known as the Cleveland Hospital Council, that splendid institution known as the Cooley Farm, and some of the most progressive ideals that have permeated and that have been set to work there are worth studying, and the committee felt that no wiser use could be made of the convention's spare hours than to learn new methods and get new inspiration from so progressive a center.

Cleveland has grown rapidly in the last decade, from a city of 300,000 ten or fifteen years ago to a city of a million people today, from a place down among mediocrity to one of the most commanding positions among American cities.

Cleveland has vast wealth, and, what is far more important, vast ambitions, and one who visits Cleveland for even a brief sojourn cannot help but be impressed with the fact that the spirit of Tom Johnson still hovers over the city and that the impetus, the ideals, and the social progress which center there were inspired by that same genius for social organization. Under Tom Johnson were trained the men in whose keeping the welfare of Cleveland now rests.

As we are now going to Cleveland we should have before us a brief summary of what we may be expected to find there, and we have tried to give our readers the benefit of this information.

* * * *

WAR LEADERS ON THE PROGRAM

Social Gaiety Prevented by Gravity of the Hour—Study of Local Welfare Work to Be Only Interruption in Epochal Gathering

Although President Wilson of the association has made up a splendid program for the Cleveland meeting, one full of meat and of the most vital problems of the hospital world at this epochal time, it has been announced that it may be necessary, in the interest of an even more timely discussion of some matters which are coming to a focus just at this moment, to change the program in some particulars for the inclusion of representatives of the Army, Navy, and Public Health services of the government and the Council of National Defense.

It is certain that we will have with us at that meeting representatives of those services, although General Gorgas, General Braisted, and General Blue may be so overwhelmed with the feverish work of war time that they may not be able to come in person. It is certain that we will have with us Dr. Franklin H. Martin, president of the General Medical Board and a member of the advisory commission of the Council of National Defense. Dr. Martin's board has achieved wonders in preparing the medical services of the country for war, and it may be safely stated that, however unprepared the Congress and the public are for the war, the medical services of the country are ready and are now fulfilling all that is asked of them. Thanks to Dr. Martin's initiative and his aggressive energy, more than ten thousand medical men are now avail-

able and many of them at work in every field. Dr. Martin will tell us something of the herculean task that confronted him and his associates, and he will tell us—which is far more important—what is to be expected of the profession, hospitals, nurses, and trained hospital employees. We must keep close to Dr. Martin during these feverish days, because he is the friend at court upon whom we must rely if the hospitals are to have that intimate association and that protection which only the government can give. In connection with Dr. Martin's address a resolution will be introduced in the association asking for the appointment of a committee to wait upon the proper governmental authorities and to request that the government associate with itself, in whatever protective measures are necessary, the hospitals of this country, especially in fuels, foods, and hospital and medical supplies.

THE PRESIDENT'S ADDRESS

President Wilson must address himself this year to the war and the changes it has made and is making in the hospital world. He has been in close association with the surgeon-general and other branches of the government, and knows what has been done and is being done, and he will bring to us firsthand information.

Dr. Wilson must also address himself to the changed conditions in the American Hospital Association due to our new charter created last year, which provided for a board of trustees and a permanent secretary. More has been done during the past year for the hospital people by the American Hospital Association than in all the years before, due almost entirely to the creation of a permanent secretaryship under the wise leadership of the board of trustees selected by the association and in virtue of the outstanding leadership of the members.

THE SECRETARY'S REPORT

Dr. Walsh has been busy during the past year. He has established a bureau of information, an employment bureau, and a most serviceable news bureau by which members of the association are kept in quite intimate touch with what is going on. Dr. Walsh has also been active in increasing the membership of the association. For the first time in its history the association has now several life memberships, and the initiative has been taken to increase this class of members, thereby greatly increasing the funds of the association. Every life member must pay \$50. Dr. Walsh will tell us about his work, and it is extremely important because this is the first year that we have had a permanent paid secretary.

REPORT OF THE BOARD OF TRUSTEES

Mr. Borden will without doubt make the report for the board. It was Mr. Borden who did most of the work in creating the new constitution, and he will tell us how it has worked during the year, especially as he has also been a member of the board of trustees during the past year. Undoubtedly Mr. Borden will have found that certain changes in the constitution are still to be made, and recommendations for those changes will enter into his report. On the whole, the new constitution seems to have worked out well.

TUESDAY AFTERNOON

Dr. Donald E. Baxter, director of the work of the New York Committee on After-Care of Infantile Paralysis cases, is to read a paper on the organization and operation of that famous piece of work. The New York Committee on After-Care raised a fund of several hundred thousand dollars, partly the donation of the Rockefeller Foundation, and through the committee's agency many of the three thousand children who were stricken by the poliomyelitis plague during that unprecedented epidemic are now on the way to good health and the use of their limbs. Heretofore this country has been dotted with paralyzed people whose condition was due to infantile paralysis, and the New York committee has succeeded in showing us the way whereby a very large percentage of these heretofore helpless cripples may now be restored to society in perfect health.

now conducting dispensaries and doing out-patient work, whereas only a very few had been doing it before their interest was aroused by this association.

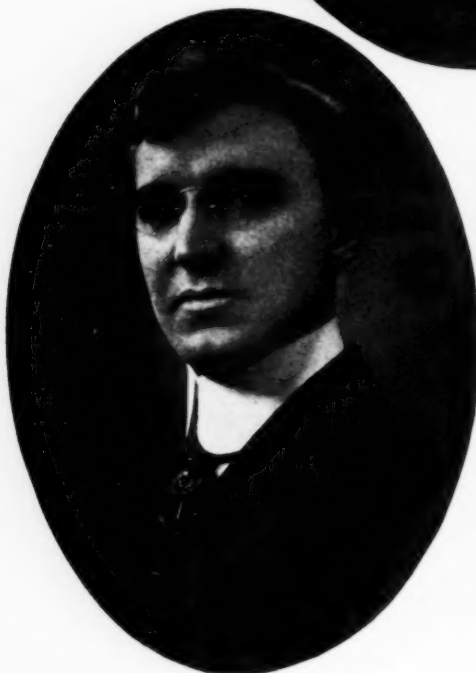


VENEREAL WORK

It was the custom of the general hospitals of the country until a year or two ago to refuse to accept patients suffering from the venereal diseases. Thanks to a very vigorous campaign that has been conducted and supported enthusiastically by the association, most of the hospitals are now accepting these patients, the technic of their care has been developed, and hospital administrators are now permitted to feel that they can accept these patients without fear of the destructive cross-infections of the recent past.

HOSPITAL PUBLICITY

Only a few years ago it was considered highly unethical for hospital administrators or trustees to give out for pub-



DR. ROBERT J. WILSON,
President American Hospital Association,
Superintendent New York Hospitals, New York City.

DR. WILLIAM H. WALSH,
Secretary,
Philadelphia, Pa.

MR. ASA BACON,
Treasurer,
Superintendent Presbyterian
Hospital, Chicago, Ill.

OUT-PATIENT WORK

Mr. Davis is to bring out-patient work down to date. It is only a year or two since our association became actively interested in out-patient work, and I think Mr. Davis will be able to tell us that many hundreds of hospitals are

licating any news from their institutions. The result was that there were hazy notions in the public mind as to what the hospitals really stood for and what they were doing. All this has now been changed, and it is regarded as one of the best forms of progressive service for a hospital to

b. in close touch with the public in its community. Where that is the case, the public has found new interest in their hospitals and are supporting them with a generosity never before attained. Mr. Frederick D. Greene, of New York City, has been at the very front of this propaganda for publicity, and is to address the convention on the subject of publicity as a means of education and support. He has

of careful examination and diagnosis of any incipient disease that might be cured. There are many varieties of health insurance and Dr. Goldwater has been a deep student in this field; therefore his paper on health insurance should be of most timely interest. On this same general subject is Dr. Thomas Howell's paper on "Workmen's Compensation Laws and Their Relations to Hospitals."



a most attractive subject and, as its first exponent in the country, will undoubtedly give us much instructive information about it.

Late Tuesday afternoon there is to be a business meeting, which will be attended by the active members of the association. Reports of committees and consideration of reports that have already been made will be the order of this business meeting.

WEDNESDAY MORNING

Health insurance is attracting an immense amount of attention at the present moment; nearly every legislative body in the country has discussed it; many states have passed laws on the subject and the Federal Congress has had before it many laws for the protection of governmental employees by way of health insurance. In New York City about two years ago Dr. S. S. Goldwater, then commissioner of health, instituted one form of health insurance in the critical examination of every employee of the health department, not only to prevent the infection of others by city employees, but in order to guard the health of those employees themselves, by way

These two papers will undoubtedly bring up the whole subject of social insurance.

In this era of hospitalization of the great mass of the people we have almost forgotten an evil that was pronounced in former days, namely, hospitalism, or, as we formerly called it, "chronic hospitalism." The great public hospitals, including municipal institutions, almshouses, and state hospitals for the insane, are still subjects of great abuses from what a former generation called "hospital rats"; that is, patients who sought by one means or another to continue their residence in free public institutions. The day is past when hospital boards and those

charged with the financial operations of philanthropic institutions are expecting to derive results from the work of patients, and we are thinking in a new way about the work of patients and convalescents. We are now calling it "work therapy," and instead of occupations in institutions being selected by and done under the direction of head janitors and housekeepers, physicians attending patients are now prescribing that work; and, as we are making better diag-

DR. A. R. WARNER,
First Vice-President,

Superintendent Lakeside Hospital,
Cleveland, Ohio.

DR. D. L. RICHARDSON,
Second Vice-President,

Superintendent Providence City Hospital,
Providence, R. I.

MISS GEORGIA M. NEVINS,
Third Vice-President,

Superintendent Garfield Memorial Hospital, Washington, D. C.

noses than we used to make, and since we are now attempting to cure patients that were relegated by a former generation to the "scrap heap," there are fewer excuses for hospitalism. The "hospital rat" is being classified and labeled and a proper niche is being found for him, and he is being compelled to take his place as a potential asset of the country. Mr. Pliny O. Clark, of West Virginia, will talk on this subject.

The remainder of the morning session will be devoted to discussions of the war. Major Winford H. Smith, Medical Reserve Corps, U. S. A., will speak on the topic of "The Reorganization of the Civilian Hospital on a War Basis." This is our old friend and former president, Dr. Winford H. Smith, of Johns Hopkins Hospital, now on duty as a major for the war, in the surgeon-general's office at Washington. No one knows better than Dr. Smith the universal and radical changes that have taken

find funds and create the necessary facilities for the re-education of the maimed and wounded back from the war. This subject will be most interestingly treated by Major Smith.

Col. Jefferson R. Kean was to have followed with a discussion of "The Role of the Civilian Hospital in War Time," but since this program was arranged Colonel Kean has been ordered to France at the head of the American ambulance organization and as this comment is written he is already on the water. His place will be adequately filled in the program by someone now in command in the Red Cross.

WEDNESDAY AFTERNOON

At the Philadelphia meeting of the association a committee of three was appointed, with Dr. Winford H. Smith as chairman, to work as part of a joint committee on stand-



DR. WINFORD H. SMITH,
Trustee (two years),
Superintendent Johns Hopkins Hospital,
Baltimore, Md.



MISS MARY L. KEITH,
Trustee (one year),
Superintendent Rochester General Hospital,
Rochester, N. Y.

place in our hospitals due to the war. Many hospital administrators themselves do not yet realize that their institutions have been greatly affected by the war; but their staff members and interns have been taken, their nurses are scattered over the battlefields of Europe, their orderlies and trained people are with base hospital and ambulance units, and supplies of all kinds have gone up in price sometimes to prohibitive points; and notwithstanding these handicaps the hospitals are asked to mobilize themselves and be prepared to perform a vastly increased service not only for the civil population, in order that the work of physicians and nurses may be concentrated and thus time saved, but also for the actual care of the sick and hurt of the war itself. Many hospitals have already announced the creation of special units to perform operations on prospective candidates for enlistment in order that slight deviations from normal and readily curable conditions may be surgically remedied and the men fitted for acceptance in the army. Publication has been made in several parts of the country, also, that groups of people working about their community hospitals are organized to

ardization, and Dr. Bowman, at Philadelphia, announced the creation of a large fund at the disposition of the American College of Surgeons to carry on this work. During the past year something has been done, a number of meetings have been held and at least an outline of the work has been made. It is now expected that this work will go forward intensively. In another place in this issue will be found the announcement of a great meeting to be held in Chicago to discuss the standardization of hospitals. THE MODERN HOSPITAL is now publishing a series of articles on standardization, largely for the purpose of blazing the way for the work of Dr. Bowman's and Dr. Smith's committee. Dr. Smith is to tell us at Cleveland what has been done, how the work has been diagrammed, and what the next steps are. It means much to hospitals to know what is going on in this direction.

Details of management seem to attract little attention on programs. Those who address conventions seem to prefer to talk high up in the air, and to that extent the message they bring is lost to the one most needing it. Fortunately our program at Cleveland is to be enriched by much dis-

cussion of hospital details. Two of these papers occur at this point in the program, one by Miss F. A. Blanchfield, Bellevue, Pa., on "The Superintendent's Responsibility for Correct Dietary" and the other by Dr. Walter Morritt, of Colorado Springs, on "Practical Hospital Economics."

Another business meeting occurs at 4:30 o'clock on this day.

In the evening the program is given over to a discussion of Hospital Finances and Accounting. Dr. A. R. Warner, of Lakeside Hospital, Cleveland, has been chairman of a special committee on hospital accounting for the past two years; he will open the discussion with a report on what his committee has done during the past year. Mr. Cornelius S. Loder, efficiency engineer, of New York; Dr. A. C. Bachmeyer, of Cincinnati; Mr. Howell Wright, of Cleveland, secretary of the Cleveland Hospital Council; and Mr. F. E. Chapman, of Mount Sinai Hospital, Cleveland, will participate in this symposium.

We are getting somewhere in hospital accounting, and without any question the next year or two is to develop new forms by which hospitals may compare their results with the results attained in other institutions, and when a basis of comparison is achieved we may expect radical improvements in our service and in our savings.

THURSDAY MORNING

On this morning the convention breaks up into two sessions, one of the large hospitals and one of the small, for the discussion of problems rather special in character. In the section on large hospitals, Dr. John M. Peters, of Providence, reads a paper on "Oil as Fuel." This is a new fuel as applied in hospitals and is undoubtedly offered to hospitals by way of new kitchens and boilers for its operation. If there are economies to be made by the adoption of oil as fuel we should be anxious to know about it, especially those of us who have in contemplation new hospital buildings.

Dr. H. G. Goodwin, of the Albany General Hospital, will read a paper on "The Hospital, a Teaching Institution." As THE MODERN HOSPITAL has insisted many times, all hospitals are teaching institutions, some of them connected with medical schools and some of them by reason of having training schools, and certainly all of them as factors in the education of medical men, nurses, and the public. Dr. Goodwin is well qualified and has some new viewpoints on this subject.

Heretofore research work in hospitals has not created much excitement. Many hospital superintendents and many of our trustees regard research work as something with which the administration has little if anything to do. That time has passed now and the research work of the modern hospital is recognized as peculiarly within the province of the hospital superintendent; not that he has to be responsible for the quality or character of the work, but he cannot avoid responsibility for the facilities and equipment for doing the work. Many times also he must see that there are proper people to do it, and it is also peculiarly his province to see that the interns in his hospital live up to their obligations in respect to the research work of the institution.

One of the hospitals in which this progressive ground has been accepted is the Minneapolis City Hospital, and Dr. H. O. Collins, superintendent and city physician, will tell us how the work is going and give us the viewpoint of the medical staff and the medical profession generally, as well as the administrator in charge of it.

There is a peculiar problem in municipal hospitals regarding training school service; many of these institutions

are restricted under political necessity, many others are subject to influence of one sort or another, and in all of them are conditions vastly different from those that prevail in hospitals of other classes.

Dr. Cleveland H. Shutt, hospital commissioner of St. Louis, formerly superintendent of the St. Louis City Hospital, will give us a most interesting paper on this subject, with a discussion by Dr. A. B. Ancker, of the St. Paul City and County Hospital, who has one of the best institutions of this kind in the country.

In these days of preparation for war the necessity to provide for the health and welfare of the civil population cannot be neglected; and it is going to be a hard task for anyone carrying responsibility for the welfare of the folks at home when all of our interests and our sentiment are going out to the boys abroad. Surgeon-General Rupert Blue, of the United States Public Health Service, is charged with this responsibility at this critical time, and he will be at Cleveland to tell us what the problem is, how it is proposed to be met, and what the duty of the hospital superintendent is; an important part of the paper is to be devoted to advice as to how our hospitals back home can aid the government.

SMALL HOSPITAL SECTION

We said early in this comment that we would have many papers and much discussion about details of hospital administration at our Cleveland meeting, and this "small hospital" symposium is to be a veritable wealth of discussion on these small but important problems.

Miss Alice Cleland, of Northampton, Mass., will discuss "The Relation of the Superintendent to the Governing Board and His Obligation as Admitting Officer"; Dr. W. T. Graham, of the University of Iowa Hospital, takes the subject, "The Obligation of the Community to Support Adequate Hospital Facilities"; Miss Nellie Parrish, of East Liverpool, Ohio, discusses "The Laboratory for the Small Hospital"; Mr. Joseph Geffen, of Philadelphia, Pa., "Visiting and Visitors"; Dr. H. J. Moss, of the Jewish Hospital, Baltimore, "The Economical Use of Supplies"; Miss Ida Barrett, of Grand Rapids, Mich., who has just finished her fine new hospital, the Blodgett Memorial Hospital, will discuss the qualities that make a good superintendent of nurses.

AFTERNOON

Thursday afternoon is to be devoted to a round-table for the Large Hospital Section, conducted by Mr. Daniel D. Test. A business meeting will end the afternoon session, at which Dr. Renwick R. Ross, of the Buffalo Hospital, chairman of the nominating committee, will present his report of nominations for officers for the coming year.

FRIDAY

There is no more important problem in our hospitals at the present time than that concerning the medical staff, especially since we are now coming upon a time when definite and restricted hospital staffs seem to be the order of the day. Dr. H. L. Foss, of Danville, Pa., will discuss this problem. Dr. Foss was for some years connected with the Mayo Clinic at Rochester, Minn., and he is now administrator of the splendid new Geisinger Memorial Hospital.

Dr. George O'Hanlon is to report for the committee on legislation. As we have said elsewhere, nearly every state in the Union at every session of the legislature has many bills introduced affecting hospitals favorably or otherwise, and there is no more active duty on the part of the American Hospital Association than to keep its members thoroughly posted as to the effect of the proposed legislation in the several states. One of these days the association

must have a committee in each state whose business it will be to handle these problems of legislation in a unified, constructive way; and the association, when that time comes, will be called upon to rally around its committees and to help them in their attempts to mold legislation from the standpoint of the hospitals and the public health.

When the war broke out, a committee of hospital men was appointed on preparedness. Dr. F. A. Washburn, of the Massachusetts General Hospital, was made chairman, and this committee has done very much, not only to mobilize the civilian hospitals for war, but to help them in their efforts to meet the requirements of the government. Dr. Washburn is to tell us what has been done and how, and what is to be done in the future.

Just following our Philadelphia meeting, the council on health and public instruction of the American Medical Association called a conference in Chicago to take up the question, in a national and comprehensive way, of child welfare; many semipublic health organizations were invited to send delegates. President Wilson appointed for the American Hospital Association Dr. J. A. Hornsby, of Chicago. A large conference was held in Chicago and while no definite proposals were developed, some committees were appointed to obtain statistical data as to what was now being done in the several branches of child welfare, with the end in view to proceed in some regular fashion to coordinate all the work that is being done to prevent overlapping, and to obtain the largest constructive results. Dr. Hornsby is to report at the Cleveland meeting the results of this conference up to date.

A similar conference to the above was called by the American Public Health Association to discuss the mooted problems of dispensaries and out-patient service. Mr. Michael M. Davis, of Boston, was the delegate to that conference and he will report on its deliberations.

In the afternoon, Governor Cox, of Ohio, is expected to address the convention, and, as he is an outstanding, progressive, public-spirited man who has been a public speaker for a long time, he may be thoroughly expected to launch some new thoughts and to inspire some new methods in regard to hospital service and the care of the public health.

There will be other speeches on Friday afternoon of a more or less sentimental character, thanks to everybody for everything and congratulations, if the convention has been a successful one, and the convention will close with the installation of the officers for the coming year.

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BULLETIN OF THE AMERICAN HOSPITAL ASSOCIATION

Program of the Meeting—Special Trains and Rates—
Bureau of Information—Special Features—
Commercial Exhibit

HEADQUARTERS

The nineteenth annual convention is to be held in the Hollenden Hotel, Cleveland, O., September 10-14, 1917. There will be ample accommodations there for the simultaneous meetings of two sections of the association and such other small assemblies as may be necessary. On account of the large attendance expected, it will be impossible for all members to secure accommodations at the Hollenden Hotel, and even other hotels will be crowded. All who contemplate attending should either write directly to the various hotels or request the local committee on arrangements to make reservations.

SPECIAL TRAINS AND RATES

Heretofore the local committee has undertaken the task of arranging special trains, and that body may have some announcement to make regarding the matter later. Owing to information received here to the effect that all the railroads were curtailing their service to the minimum, and that it would not be unlikely that further cuts in train service would be undertaken, it was thought desirable to complete arrangements at once for a special train from this territory. It has therefore been arranged to start a special train from New York at 4 p. m. Monday, September 10, which will pass through Newark, Trenton, Philadelphia, Lancaster, Harrisburg, Altoona, Johnstown, Pittsburgh, and Youngstown, arriving in Cleveland, O., in the early morning of September 11. The local committee will arrange to have automobiles in waiting for this train to take the passengers to their hotels.

The Big Four route offers the following special rates, in effect until September 30, which may be used in connection with the Cleveland meeting: St. Louis to Cleveland and return, return limit 30 days, \$21.50; St. Louis to Buffalo, Niagara Falls, or Toronto, and return, return limit 30 days, \$25.50 (this ticket allowing stop-over at Cleveland both going and return trip); St. Louis to New York and return, return limit 30 days, \$40—Big Four to Cleveland, New York Central to Buffalo, free side trip to Niagara Falls, New York Central Lines to New York, or option of using the Hudson River daylight steamers between Albany and New York (if the West Shore Railway is used between Buffalo and New York, the option of using the Hudson River daylight steamers between Albany and New York is also offered, at rate of \$37 for the round trip); St. Louis to New York and return, return limit 60 days, \$42.55—going, Big Four through Cleveland, thence New York Central lines Buffalo to New York and return via Philadelphia, Baltimore, and Washington, thence C. & O. through the Blue Ridge and Alleghany Mountains to Cincinnati, and Big Four to St. Louis (this ticket also carries the option of using the Hudson River daylight steamers Albany to New York). The Big Four train leaving at 5 p. m. is a very popular train for Cleveland, carrying local sleeper, arriving Cleveland at 6 a. m., remaining in sleeper until 7 a. m. Also have train leaving at 10:30 p. m., arriving Cleveland at 3:55 p. m.

The Central Passenger Association, with headquarters at Chicago, has advised that they will authorize the sale of round-trip tickets from points within Central Passenger Association territory to Cleveland, O., at the rate of two cents per mile in each direction. These tickets, which must be validated in Cleveland, will be on sale September 8, 9, and 10, with a final return limit to reach original starting point not later than midnight September 19. All those desiring to avail themselves of this reduced rate should consult ticket agents at their home towns for detail information as to fares and routes applying in connection therewith.

The Trunk Line Association, with headquarters in New York, have advised that the rate will be on all lines included in their territory two cents per mile in each direction, going and returning via same route only; tickets to be sold and good going September 8 to 10 and returning to reach original starting point not later than September 19.

The Southeastern Passenger Association advises us that there are in effect low-rate summer excursion fares from all important stations in the territory south of the Ohio and Potomac and east of the Mississippi rivers, except

Virginia and the Carolinas. These summer excursion fares will no doubt amply accommodate any passengers who will move from the Southeastern territory. Tickets are on sale daily, with final limit October 15, and allow liberal stop-overs on both going and return trips.

The Eastern Canadian Passenger Association and the Western Association declined to make any special rates.

PROGRAM

The convention will convene at 9 a. m. Tuesday, September 11, and daily thereafter at the same hour.

After the invocation there will be an address of welcome delivered by the mayor of the city, followed by the address of the president.

The remainder of the morning session will be devoted to the reports of the various officials, which will be read and referred for action to a later business meeting.

Among the special features of the program will be a paper by Dr. W. H. Smith, who is now a major in the Army Medical Reserve Corps, upon the subject of the reorganization of the civilian hospital upon a war basis; this will be discussed by Dr. John A. Hornsby, who is also a major in the Medical Reserve Corps.

There will be present a representation of the American Red Cross to indicate the role of the civilian hospital organization in time of war, and in lieu of discussion the time will be allotted to members to ask whatever questions may seem pertinent. Another subject of vital importance at this time is that of the preservation of the health of the civilian population in time of war and the extent to which civilian hospitals may coordinate their efforts with those of the government. There will be present a representation from the office of the Surgeon-General of the United States Public Health Service to present the views of the government upon this matter.

The Council of National Defense, Medical Section, will be represented by Dr. Franklin H. Martin, who will address the association upon various vital matters affecting the hospitals of the country. Dr. Martin will be prepared to indicate the policy of the council upon such subjects as drafting of interns and medical students, conscription of physicians of military age, allotment of supplies to civilian hospitals in the event of a national shortage, the standardization of instruments and supplies, and a score of kindred subjects.

The League to Enforce Peace has delegated a distinguished speaker to appear before the association to present the views of that organization as to the duty of our citizens to our country in helping in every conceivable way to carry the conflict to a successful issue and to conserve the fruits of victory by some lasting union of nations to enforce peace upon the whole world.

Another subject of absorbing interest at this time will be one upon French and American war hospital plans; this subject will be handled by Mr. Charles Butler, architect, of New York, who has recently spent eighteen months in France as a member of the American Relief Clearing House, during the greater part of which time this gentleman was detailed to the French Ministry of War as an expert on hospital construction in connection with the design of war hospitals.

In addition to the subjects above mentioned the program is replete with topics of every-day interest to the hospital administration; indeed, seldom has a program of the association covered wider scope. We desire to again state at this time that unless copies of papers to be read are in the hands of the Secretary by August 15 it may be

impossible to either publish the paper in the proceedings or to announce it in the final copy of the program.

SPECIAL FEATURES

We are straining every effort to have the government place a base hospital in active service at Cleveland during the convention in order that our members may become accustomed to the various details of organization and equipment. We have every reason to believe that our plans will be successful.

We also hope to have a display by the American Red Cross of standard supplies accepted by that organization for military and civilian relief. This display will afford an excellent opportunity to those interested to learn just what is needed by the Red Cross, and will also demonstrate the system adopted for the coordination of all relief work.

SOCIAL FUNCTIONS

Before it was definitely decided to turn the nineteenth annual convention into a movement for the mobilization of the hospital resources of America the local committee had planned various features for the entertainment of visitors. As national affairs became more serious, however, the trustees decided that it would hardly be in good taste to spend either time or funds upon purely social functions, and therefore instructed the committee to reduce their plans to a minimum. Consequently, this meeting will be one of serious business, although the local committee desires that all shall be notified that there will be open house at all local hospitals for the reception of members and their friends. It is also planned to give a luncheon to which all are invited at the Mount Sinai Hospital, one of the newer institutions of Cleveland.

REGISTRATION

We wish to impress upon everyone the very great importance of registration. Ample facilities will be afforded the members, and each one is requested to fill out the registration card before attending the first session. The records of the association cannot be accurately kept unless all cooperate with the secretary in this matter. Those who have failed to pay either 1916 or 1917 dues will please be prepared to do so at the time of registration. Please remember that apart from the proceeds from the commercial exhibit, the only income available for the support of the association is from the dues for membership. There will be a number of clerks at the registration desk and, except during the sessions, both the secretary and treasurer will be at their desks in the same room.

BUREAU OF INFORMATION

For the first time in the history of the association there will be established in spacious quarters a bureau of information at which there will be in attendance experts in almost every line of hospital endeavor. There will be on file plans and specifications for every conceivable kind of a hospital and catalogs of supply houses that furnish hospital equipment. One agent will be on hand to impart information about Cleveland, her hospitals, and other facilities.

At this bureau will also be conducted a post office and telephone and telegraph calls will be immediately delivered by special messenger service. This vast undertaking has been placed upon the shoulders of THE MODERN HOSPITAL and its staff under the immediate supervision of Drs. Hornsby, Ball, and Nolan, and Mr. Howell Wright of the local committee. It is the belief of the officers that this feature will prove of immense value to all members.

COMMERCIAL EXHIBIT

All who saw the exhibits at Philadelphia, and, indeed, the exhibitors themselves, generally agree that the undertaking was most profitable, and that the value of the convention was greatly enhanced thereby. Unfortunately, no special arrangements were made last year to provide periods for the inspection of the exhibits, and the program took up almost every available minute of time. The president, recognizing the value of these exhibits to the members, has so arranged the program as to provide certain hours to be devoted exclusively to the inspection of exhibits and for the transaction of any business that members may have to attend to. We do not believe that a more comprehensive exhibit of hospital supplies and equipment has ever before been assembled, and hospital superintendents are urged to scrutinize carefully all that may be shown. All who attend this convention are advised to take advantage of the quotations that will be made by exhibitors and place orders, particularly for staple supplies, for a considerable period in advance. We have no way of determining the length or severity of the war, but every reason to believe that we are engaged in one of the most stupendous wars ever confronting our country. As the war continues prices will fluctuate and many articles now obtainable will be either unobtainable or greatly advanced in price. Now is the opportunity for the far-sighted hospital to provide for the future.

Those who do not care to buy will be treated with the same courtesy as those who place large orders, but we expect every member of the association to utilize an opportunity to see a display that may not soon again be duplicated.

LETTER TO HOSPITAL BOARDS

We propose to send a letter to the board of managers of most of the hospitals in this country and Canada, calling attention to the advantages of the superintendent attending the convention and suggesting that the hospital meet the necessary expenses. It will be sent in care of the superintendent and we hope will be at once presented to the various boards.

This convention is perhaps the most important ever held, coming as it does at a time when the government desires to secure by every possible means the cooperation of every activity and industry. By attending the convention you will not only help your own institution by the knowledge gained, but your presence will be of national aid to the association and the government.

* * * *

WELCOME TO CLEVELAND

The Mount Sinai Hospital Management Arranges to Receive Members—A Luncheon to Be Served

To the Members of the American Hospital Association:

It is hoped that the nineteenth annual meeting of the American Hospital Association, to be held in Cleveland in September, will be the most successful meeting in the history of the American Hospital Association. Never before has there been such a need for close cooperation in and coordination of hospital activities.

The Cleveland members of the association are fully cognizant of the responsibility they must assume in the success of this meeting and are making every effort within their power to make the meeting a most beneficial one and one that will be remembered by all who attend.

We want to assure everyone of a most hearty welcome. We want you to know that Cleveland fully appreciates the honor of having you as its guests during the period of the

convention and is going to do everything possible to make your stay a pleasant one. To expedite your getting to headquarters, every train arriving during the first two days of the convention will be met at Union Station and at the East Fifty-fifth Street Station on the Pennsylvania.

Your local committee, in conformity with the wishes of the Board of Trustees of the association and in keeping with the general conditions in the country, have eliminated any elaborate entertainment scheme, but we do hope to show you some of the beauties of our city and to serve you with luncheon at Mount Sinai Hospital.

If you will come to Cleveland, absorb some of the Cleveland spirit, secure the benefits of the discussions, and take home with you some little good, we will be truly glad.

FRANK E. CHAPMAN,

Superintendent Mount Sinai Hospital, Cleveland.

* * * *

SPECIAL TRAIN FROM CHICAGO

Sherman House Headquarters for Visitors—Some Social Entertainment Provided by Committee Appointed by Trustees

For hospital people in the Central West who intend to go to the convention, there will be a splendid Hospital Special train from Chicago. Arrangements have been made for the Sherman House as headquarters and a central meeting place before the train starts. Although the time is not yet agreed on, it is likely the train will leave Chicago Monday night.

The trustees have appointed Mr. J. L. Meigs, superintendent of St. Luke's Hospital, as chairman, and Dr. E. T. Olson and Dr. C. O. Young as the other members of the Western transportation committee, and in a few days full information will be sent to all the hospitals in the Central West about the special train and other arrangements. It may be stated that a program of entertainment in Chicago has been arranged by the committee, including auto rides in the parks, visits to the newer hospitals, and a few other features. Ample funds for this entertainment are in the hands of the committee.

* * * *

HOSPITALS OF CLEVELAND

Some of the Hospitals That May Be Visited—Other Places of Interest

MOUNT SINAI HOSPITAL

The new Mount Sinai is situated on East One Hundred and Fifth Street, facing Wade Park. It has a frontage of 560 feet and a capacity of 174 beds. The cost, including the grounds, was \$590,000. There is an active out-patient service. Half of the private pavilion is now being used for a nurses' home.

THE CLEVELAND HOSPITAL COUNCIL

Cleveland has eighteen special or general "public" hospitals, all of which are represented in the Hospital Council. They include two municipal hospitals and sixteen operated "not for profit." The following are the eighteen hospitals represented in the council: Babies' Dispensary and Hospital, Cleveland City Hospital, Cleveland Tuberculosis Hospital (Warrensville), German Hospital, Huron Road Hospital, Lakeside Hospital, Lutheran Hospital, Maternity Hospital, Mount Sinai Hospital of Cleveland, Mount Sinai Hospital (Old), Rainbow Hospital, St. Alexis Hospital, St. Ann's Maternity Hospital, St. Clair Hospital, St. John's

Hospital, Saint Luke's Hospital, St. Vincent's Charity Hospital, Woman's Hospital. According to the best available statistics, sixteen of these hospitals now in operation maintain 2,197 beds. This number was considerably increased in 1916, as follows: Mount Sinai Hospital of

of the cost of their care; and free patients, those who pay nothing; (2) agreed not to rent private rooms to patients at rates less than the full maintenance cost of the rooms; (3) agreed not to rent their beds for cases for which industrial or other corporations are morally and by the Ohio laws responsible, at less than cost or to maintain such beds or give such service at less than cost.

The Hospital Council with its eighteen represented hospitals may be likened in some respects to certain voluntary or incorporated associations of large business corporations. In general, its purpose is to preserve and promote the common interests of the constituent members. While not obligated by any formal agreement the hospitals have a common obligation to assist each other as follows: by co-ordination of action and development of the most efficient methods in the performance of their various functions, thereby simplifying problems of management, preventing duplication of effort, eliminating waste, reducing



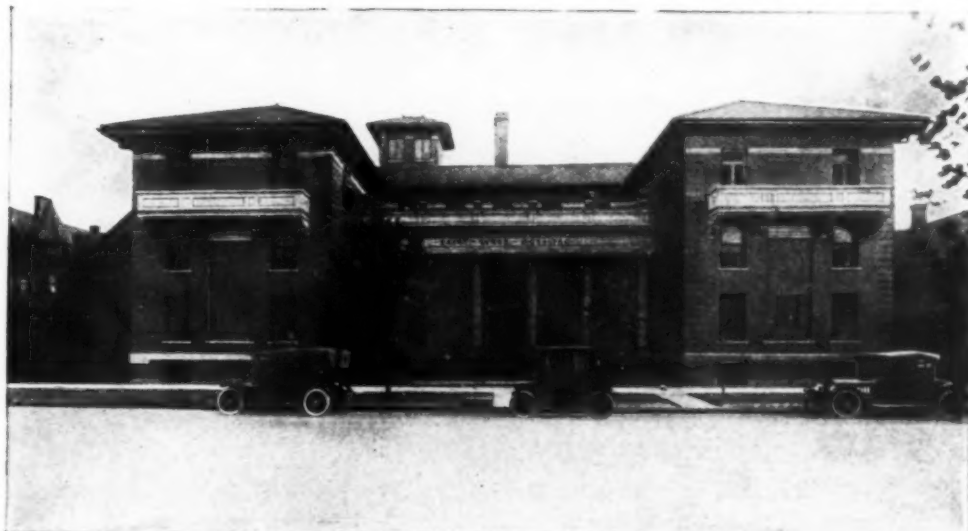
Mount Sinai Hospital, Cleveland.

Cleveland (September 1), 155; St. John's Hospital (June 1), 200; St. Vincent's Charity Hospital (September 1), 150; City Hospital (July 1), 105; and Cleveland Tuberculosis Hospital (Warrensville), 50. These hospitals will serve Cleveland with 2,857 beds.

The following are some of the things the hospitals have done through the council to increase their efficiency to the end of better meeting Cleveland's hospital needs: (1) agreed to report yearly the number of different patients cared for and the total number of days' treatment given free, part-pay, and pay patients; the pay patients to be those who pay at least the entire cost of their care; the part-pay patients, those who pay only part



Lakeside Hospital, Cleveland, showing dispensary building in center foreground, administration next, and nurses' home at distant right.



St. Luke's Hospital of the Methodist Episcopal Church, Cleveland.

costs and improving the service rendered; to give the public an intelligent accounting of their stewardship; to educate the public to a substantial degree of willingness to give moral and financial support; to initiate and favor wise local and state legislation and to oppose all legislation inimical to their field of work. While the chief object of business concerns so associated is to increase profits, the aim of the hospitals so associated is to increase the service rendered to the community. In both, however, great financial and human interests are involved.

The hospitals own land and buildings and equipment valued at \$5,169,250.

They spend for operating expenses each year \$1,169,450; for salaries and wages alone they spend \$374,000 yearly, and for provisions, hospital supplies and equipment

A fund of over \$3,000,000 is now available for the purpose of building a new hospital for Lakeside, connected with a new medical school for Western Reserve University. Plans have been drawn up and land has been selected in a high and beautiful situation in the outskirts of Cleveland and the buildings will soon be erected.



The Babies' Dispensary and Hospital, Cleveland.

\$562,975, and for other expenses, \$227,595. They have an annual income of \$1,167,800; \$330,675 being derived from tax collected funds, \$589,165 from hospital earnings (patients), \$109,010 from endowment or bequests, and \$139,065 from contributions.

In a single year they care for nearly 70,000 people, or about 10 percent of the entire population of Cleveland.

They command the services of 420 physicians and surgeons; 600 nurses, and 750 other officers and employees; 850 men and women are officially connected with the hospitals as directors, trustees, or members of committees.

THE CLEVELAND FOUNDATION

Visitors to the convention, especially those who come from large cities, should make some inquiries and study the institution known as the Cleveland Foundation. This is a new sociological organization already possessed of a fund aggregating several million dollars and intended to be a very wide-reaching civic philanthropy, as well as a promoter of educational, scientific, and altruistic activities.

Under the charter of this organization it has the right to conduct schools, hospitals, dispensaries, and almost anything else that its trustees engage in. The original purpose was to create something like the Rockefeller and Carnegie Foundations, but to finance it with the aggregate of many funds to be donated by many people.

The only activity it has engaged in up to the present is a survey of the public health situation in the hospitals of the city, and it has not gone far with this. The people of Cleveland are not all satisfied that the Cleveland Foundation is wholly altruistic, since it was conceived almost entirely by the Cleveland Trust Company, a large banking institution, and the president of the Foundation and one of its most active promoters is an officer of the bank.

LAKESIDE HOSPITAL

Lakeside Hospital of Cleveland has a visiting staff of 90 and a house staff of 24. There are 289 available beds. In 1914 there were 4,541 patients treated in the hospital; 51,984 visits were made to the dispensary. The value of the land, buildings, and equipment belonging to Lakeside Hospital is \$920,323.

ST. LUKE'S HOSPITAL OF THE METHODIST EPISCOPAL CHURCH, CLEVELAND, O.

This hospital opened July 20, 1908. Its motto is "All Healing is Divine Healing." Five buildings are occupied as homes for the 54 pupil nurses of the school of nursing. The nurses' course covers three years of theoretical and practical instruction. Literature will be sent on application. The entire plant, with equipment, cost \$254,158, \$35,000 of which came from two bequests. The hospital has 42 rooms and five private wards, with a capacity of 110 beds. Two houses are used in conjunction with the hospital, thus giving a total capacity of 140



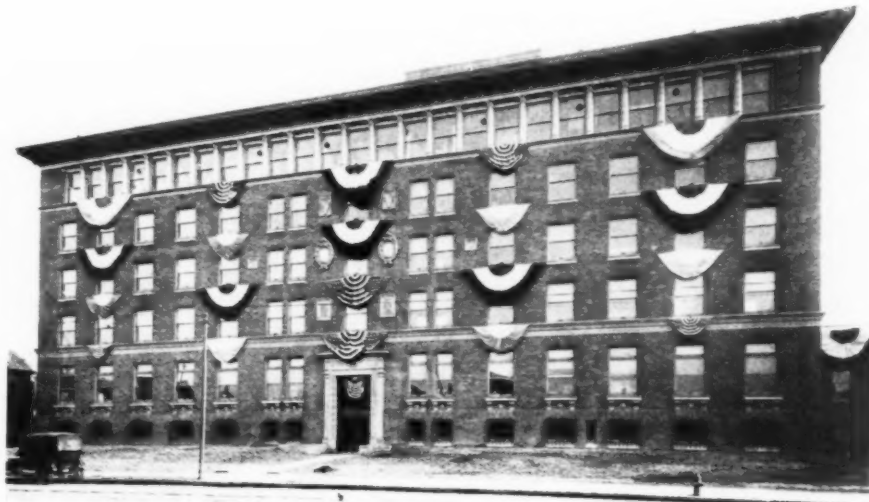
Huron Road Hospital, Cleveland.

beds. The staff is composed of some of the most skillful physicians and surgeons in Ohio. The institution is controlled by the Northeast Ohio Conference of the Methodist Episcopal Church, through a board of fifteen trustees. The year closing July 1, 1916, shows as follows: number of patients in hospital, 3,212; number of dispensary patients, 3,319; number of births in hospital, 195; number of births in homes (maternity dispensary), 247; total number of pa-

tients cared for during year, 6,531; total number of patients cared for since opening date, 30,668; charity and part-pay service for year cost hospital \$37,902.72. Receipts from patients, \$90,490.76; miscellaneous receipts, \$2,679.96; total receipts during year, \$93,170.72; ex-

dispensary, where only sick babies are admitted, in charge of a medical director, a superintendent, a physician in charge, six physicians, and three supervisors; a central milk laboratory, with eighty distributing stations; an outdoor ward, during the summer months, with a nurse in charge, two interns, six nurses, five nursery maids, and a wet nurse; a radiography and photography department, with a nurse in charge; a nurse who gives massage and electrical treatment in cases of infantile paralysis.

The innovation of charging graduated fees has been successfully put in practice. The plan is justified less as a way of producing income than as a means of preserving the self-respect of patients, who usually prefer to pay. The number of individual patients treated at the central dispensary in 1915 was 3,290; there were 4,478 cases registered in the fifteen prophylactic dispensaries. One hundred were treated in the hospital, in which there are 21 available beds. There were 9,076 patients receiving milk, of whom 957 were charity cases. For preven-



New surgical pavilion of St. Vincent's Charity Hospital, Cleveland.

penditures during year, \$106,074.63. The officers are as follows: president, F. F. Prentiss; vice-president, C. G. Watkins; secretary, J. R. Mills; treasurer, William H. Hunt; superintendent, C. B. Hildreth, Ph. G.

THE BABIES' DISPENSARY AND HOSPITAL

The object of the Babies' Dispensary and Hospital, situated at 2500 East Thirty-fifth Street, has been thus stated:

"To prevent, cure, and study sickness in babies and children, from



Cleveland State Hospital, Cleveland.

tion of blindness, 880 infant patients were visited. Boarding homes were found for 175 babies. The value of land, buildings, and equipment belonging to the Babies' Dispensary and Hospital is \$139,833.

HURON ROAD HOSPITAL

At the close of the Civil War, Mrs. H. B. Tuttle, president of the Ladies' Sanitary Commission, organized a society known as the Ladies' Aid Society for the purpose of conducting a hospital. The property was secured on Wilson Street, and the first hospital in the city was organized, the parent of the present Huron Road Hospital.

In 1867 an out-patient department for the relief of the worthy poor was established on Seneca Street by Dr. H. F. Bigger. In 1868 the medical

school secured the property on University Heights, known as the Humiston Institute, and the Wilson Street Hospital was removed thereto, as was also the Good Samaritan Dispensary.

both the medical and the social standpoint, and to educate physicians, nurses, nursery maids, mothers, and the public in general, in the care of infants and children."

The principal features of the institution are: a central



St. John's Hospital, Cleveland.

After a number of years, namely, 1874, the hospital was incorporated and secured its present location on Huron Road. The present main building was completed in 1881 and the annex in 1885. The annex was built to accommodate a training school for nurses which was organized in this hospital in 1883, and was the first training school west of the Alleghany Mountains.

Since its conception to the present time the hospital has been devoted largely to the care of accident-surgical cases. An increasing number of cases year by year corresponding to the growth of the city has largely determined the type and character of the work in this institution. Seventeen hundred patients have been treated in the hospital in a year, and over 2,000 in the dispensary.

The hospital association owns a beautiful lot overlooking a boulevard where it expects to build in the near future. The land, buildings, and equipment are valued at \$200,000.

ST. VINCENT CHARITY HOSPITAL

St. Vincent Charity Hospital, under the management of the Sisters of Charity of St. Augustine, antedates all the other local hospitals in Cleveland, having been founded in 1865. The main building, on East Twenty-second Street, cost \$72,000 and originally had a capacity of eighty patients. In 1872 an amphitheater was added, and in 1873 a three-story brick building was erected on Marion Avenue, almost adjoining the hospital, which served as an infant asylum and maternity hospital until January, 1902, when this branch of the service was moved to Woodland Avenue and the Marion Avenue building was converted into a nurses' home. In 1898 additions providing for eighteen patients were made to the main building, and in 1901 a three-story brick building was erected on Central Avenue to house the surgical division for women. The free dispensary was opened in 1894; it now has an average daily attendance of seventy. In 1898 the training school for nurses, which now has fifty-four pupils, was opened. The new surgical pavilion, which is shown in the illustration, was dedicated April 15, 1917. Over 2,500 patients were treated in the hospital in a single year, and over 20,000 in the dispensary. The land, buildings, and equipment are valued at \$377,490.

CLEVELAND STATE HOSPITAL

The Cleveland State Hospital was opened for the care of the mentally sick March 5, 1855, in what was then a veritable wilderness, south of the city of Cleveland; today a part of Cleveland, the sixth city, it stands a massive and imposing structure of gray stone and brick in a scenically beautiful park, high above Lake Erie and the manufacturing level of the city, the natural facilities for good air being exceptionally good. About the grounds are grouped the different buildings which go to make up a complete institution.

The hospital has 101 acres of land, about 25 acres of which is utilized for intensive gardening purposes, and the rest is covered by buildings and devoted to lawns.

The buildings, equipment, and land are valued at \$1,750,000. The hospital district comprises Cuyahoga, Geauga and Lake Counties.

At the close of the fiscal year ending June 30, 1917, there were 1,980 patients on the hospital records.

ST. JOHN'S HOSPITAL

The capacity of St. John's Hospital is 210 beds. It is of strictly fireproof construction, and has a pathological laboratory, x-ray and hydrotherapy departments, and 16 sun porches.

THE COOLEY FARMS

The "Cooley Farms" is the one big overshadowing institution of Cleveland's public service. It is an outgrowth of the ideas of the late Tom L. Johnson. This is a group of



Fig. 1. Courtyard and "cloister" of the colony group for aged men and women, Cooley Farms, Cleveland.

farms aggregating 2,000 acres, owned by the city, and situated 15 miles out, on a high, rolling plateau.

The "Farms" was named for Dr. Harris G. Cooley, a national figure in social and health service, and for many years director of welfare of the city.



Fig. 2. Cottage for aged couples, Cooley Farms, Cleveland. The idea is not to separate old married people who are dependent.

There are many public buildings on the "Farms," and several rather old farm houses, taken over with the purchase of the various farms that go to make up the institution. At the present time the colony group is the center



Fig. 3. Tuberculosis ward, with kitchens and dining rooms in front center of picture. Note porches for patients on both floors.

of the farms, and the largest unit. It is composed of dormitories for old, dependent men and women, a service building, and a smaller building for aged couples, old, de-

pendent men and their wives. That these old couples should be permitted to finish their days together was one of the ideas of Tom Johnson.

Then there is the tuberculosis group, for men, women, and children, and a service building for them. The third group is the so-called correctional group, where petty offenders are housed. These people are not locked up as most prisoners are, and are free to run away if they like. Visitors should inquire as to the reasons why only a very small percentage of the prisoners do not run away.

The fourth group is the hospital, which is not yet completed, but which will be one of the show places of the "Farms" when it is completed. There will be housing for convalescents sent out from the various city institutions, a psychopathic ward, and a general hospital for those resident on the Farms.

There is a herd of pure bred Holsteins whose product goes to the Babies' Dispensary and to the City Hospital, the beginning of a poultry plant, magnificent truck gardens, and big grain acreages.

The Cooley Farms is the most ambitious welfare project that an American city has ever undertaken.

VOCATIONAL WORK FOR THE BLIND IN MASSACHUSETTS*

Special Service Offered by the Massachusetts Commission for the Blind—Teaching, Aid in Securing Employment, Counsel, Help, and Recreation

BY LUCY WRIGHT, General Superintendent of the Massachusetts Commission for the Blind, Boston.

The work of the Massachusetts Commission for the Blind is perhaps most simply outlined in the following summary designed for enclosure with letters:

Blind persons may ask at this office for:

Home teachers, who will visit them in their homes and

Shop-employment, which is given especially to men and women who cannot readily find work alongside the sighted, as rapidly as vacancies occur and as the business grows. Shop industries are, for men, mop-making, rug-weaving, broom-making, and willow work; for women there are chair reseating, fabric-weaving, and braiding of old-fashioned rugs.



Fig. 2. The State of Massachusetts sends blind teachers into the homes of other blind persons to show them how to read by touch.



Fig. 1. Class in willow work under the Massachusetts Commission for the Blind.

teach reading by touch, the use of the typewriter, sewing, knitting, reseating of chairs, etc.

Use of salesroom, where things that are well made by the blind, whether in their homes or in special shops, are sold upon their merit.

*The illustrations accompanying this article are shown by courtesy of the Association for the Blind.

Expenses of special training for blind persons of promise approved by the board.

Aid in equipment, tools, etc., when needed for starting home industries for blind workers of promise approved by the board.

Counsel and help in securing work alongside the sighted, if possible, and in securing the service of schools, hospitals, relief funds, etc., for which blind persons like others are suitable applicants.

Recreation, including visits to the James A. Woolson House (a social center for blind women) and Thomas Park House (a social center for blind men), concert tickets and other advantages offered through the Massachusetts Association for Promoting the Interests of the Blind.

What this outline, planned to answer questions in the minds of blind persons and their families, does not suggest is various forms of special service offered the community.

At the central office, for example, which is a clearing house for matters relating to the blind, a register of the blind of the state is maintained. From this office field workers go to all parts of the state to visit the newly blind. At the central office is located, too, not only the bureau of information, advice and aid for the blind, which has been previously described, but a center for study and cooperation in non-medical work for prevention of blindness and conservation of the eyesight.

ORGANIZATION

The organization behind these forms of service is that of a board, of five unpaid members, appointed by the governor for terms of five years. The commission works under a law of 1906, which limits its work largely to the educational and industrial field by the proviso "that the commission shall not undertake the permanent support or maintenance of any blind person." The work of the commission has been extended since 1906 by acts of 1916 which provide for "Exchange of Information between the State Board of Charity and Overseers of the Poor and the Massachusetts Commission for the Blind, and to provide for Aiding Persons with Seriously Defective Eyesight"; and "for the Instruction of the Adult Blind at their Homes."

The management and immediate charge of the department is in the hands of a general superintendent with a staff of workers variously equipped for the somewhat specialized fields of work included in the following divisions: (1) central office; (2) salesroom and special sales; (3) local shop system; (4) Cambridge Industries; (5) Woolson House Industries.

RESULTS

Among the more important results of ten years' work have been an effective campaign for prevention of blindness and conservation of eyesight, the initiation of sight-saving classes in the public schools of several cities, and the development of industries for the blind, of which the following industrial summary is perhaps the briefest outline:—

INDUSTRIAL SUMMARY

Year	State Appropriation	Number Reached	Number Materially Benefited	Number Given Industrial Training	Number Employed Regularly in Commission's Shops	Earnings of Blind in Commission's Shops (Salesroom and Staff)	Total Sales
1906-07,	\$40,000.00	698	464	57	68	\$ 8,353.82	\$12,612.97
1907-08,	40,000.00	676	392	77	84	13,769.98	18,754.79
1908-09,	45,000.00	784	380	40	86	19,502.52	34,669.40
1909-10,	45,000.00	818	400	39	96	25,050.53	53,029.50
1910-11,	50,000.00	876	464	42	90	29,544.92	67,331.98
1911-12,	57,781.04	2,081	584	28	99	35,183.17	54,592.56
1912-13,	65,000.00	1,149	600	26	112	40,543.33	55,556.24
1913-14,	67,000.00	1,695	750	20	113	42,205.55	50,737.43
1914-15,	67,005.45	1,847	800	22	113	45,010.04	75,671.06
1915-16,	71,210.23	2,363	1,043	32	132	50,350.82	88,692.18

THE CHICAGO LIGHT HOUSE FOR THE BLIND*

It Sheds Light on Many Darkened Pathways—Two of Its Pupils Write of Its Work

A representative of THE MODERN HOSPITAL, in going through a large Chicago department store, noticed some attractive old-fashioned rag rugs, of the kind that have lately become fashionable, and was told that these were the work of blind persons. Some, it appeared, were made in Massachusetts, under the auspices of the Massachusetts Commission for the Blind, whose work is described on another page by Miss Lucy Wright. Others were made in Chicago under the direction of a private organization known as the Chicago Light House for the Blind, for information regarding which THE MODERN HOSPITAL's representative was referred to Mrs. C. T. Hood. Mrs. Hood, having been requested to furnish THE MODERN HOSPITAL with some account of the Chicago Light House, was kind enough to secure for us the two articles which follow.

*The illustrations accompanying this article are here shown by courtesy of the Chicago Light House for the Blind.

Both were written by cultured blind persons who are pupils of the Light House. Both manuscripts were typed in excellent form by the authors (about twenty-five members of the Improvement Association for the Blind, mentioned below, use the typewriter), and have been set up as written, with no more than the slight editorial changes always necessary for conformity to style.

* * * *

The Needs and Welfare of the Blind

BY S. H. AUSTIN, Chicago.

The blind may be divided into three classes; those who lost their sight after middle age, those who lost their sight before 5 years of age, and those who lost their sight between the ages of 5 and 30 years.

Those who lose their sight after middle life seldom become reconciled. They realize their awful condition, and the shock of their affliction is so terrible that it robs them of all their ambition and vitality. The clouds of gloom gather so thick about them that not a ray of sunshine can enter their soul; it seems almost impossible to regain hopes and courage. Therefore, not being able to adapt themselves to their condition their future is blank.

Those who lose their sight before 5 years are dearly loved by their parents, who would do almost anything for their happiness, but who make one sad mistake—they forget the future. Take a beautiful house-plant; put it into a dark cellar without light and air; it soon loses its luster, grows weaker and weaker, dwindles away, and dies. The little child set down in a chair without sunshine, fresh air, and exercise, like the plant, cannot develop. The child is not permitted to move about for fear it may get hurt; thus, when it is of age, it is a little, weak, scrawny creature. It has not been taught anything and grows up into an ignoramus and, sometimes, an imbecile. When its parents are gone, it is a candidate for a charitable institution, or the public almshouse.

Those who lose their sight between the ages of 5 and 30 years constitute the industrial class. They are sent to the school for the blind at Jacksonville, Ill., where they receive an education, both mental and physical. They become fully developed, and also learn music and some trade. They are as the colored people were after the war; they have no homes, no money, and no experience. Some of these who make themselves attractive and who have an over amount of ambition succeed in getting a helping hand from their friends and do well. Others who are not so fortunate can only drift where the winds drive them; they can take their tin cup, stand on the street corners seeking alms from the passersby, or seek shelter in some charitable institution.

If the public is interested enough in the blind to give them an education, then they should go a step further and provide opportunities for them to utilize the advantages acquired at school and opportunities that will make them producers of wealth instead of objects of charity.

Illinois, in 1894, built the Industrial Home for the Blind, which was to give the blind employment and an opportunity to earn an honest and comfortable living. This was a grand and noble idea, but politics would occasionally appoint a man for superintendent who was incompetent for the position and indifferent to the welfare of the blind, and whose aims and motives rose no higher than the filling of his pockets and fat living at the expense of the state. Through such incompetent management the factory became a sinkhole for public funds. Because of this great waste there was a sentiment for a year or two to abolish the home, but Chicago politicians would not agree to such

an action. So such evils had to endure for a time. From administration to administration conditions naturally grew better, till now thirty blind men support their families almost entirely by their earnings from their work in this factory.

Thirty years ago a man with all his faculties and a little means could go into business and compete with the world and succeed. Today that same man would soon be crushed by capital and monopoly and would soon be forced out of business. If a man with all his faculties cannot compete with the present conditions, then it would be folly for a blind man to undertake business singlehanded. Cooperation of labor is the only safeguard to success in an industry; or, in other words, concentration of efforts, wealth, and labor. As the blind are poor and have no means, it is impossible for them to concentrate their efforts and labor without the assistance of charity.

About ten years ago I became acquainted with Mrs. Hood, and through this acquaintance she became interested in the welfare of the blind. She and some of her near friends set to work to assist the blind and to find employment for them. She soon found that her efforts were useless, for the blind could do only certain kinds of work. And, besides that, employers did not like to hire the blind, because they required a little more waiting on than a sighted person, and because they were afraid that they might get hurt and that they would be responsible for the damage; and they did not care to accept such a responsibility. And, besides that, a sighted workman could turn out more work and make more profit for the employer.

She soon realized that the only hope of success for the blind was an industrial center where the blind could meet and get the employment that they could best do and that would be the most remunerative.

The workshops in the Eastern states were running successfully, and the blind were making a comfortable living there. She concluded that the blind of Illinois were just as bright as the blind were in the East, so she organized the Improvement Association for Blind People, and began plans for an industrial center. This movement was finally launched a year ago this spring, when they purchased property and located at 3321 West Twenty-second street. They named the place "The Light House."

Broom-making and rug-weaving are the most suitable trades for the blind, and the most remunerative. As there are no rugs imported from the European countries at present, the American rug factories have more than they can do and cannot supply the demand. The high prices obtained for rugs make it a very profitable industry, as these high prices are likely to be retained for some years to come. Rug-weaving is likely to become the most remunerative industry for the blind.

The Light House is badly in need of more room and space to develop this industry and to teach broom-making. It is sincerely hoped that people with means may become interested in The Light House and the welfare of the blind and that new buildings may soon be erected. In this way these industries may be developed and the great opportunity that the blind have so long looked for may be realized—they will have steady employment and will make a comfortable living for themselves and their families. It is opportunity they want, not charity.

* * * *

The Story of the Light House

BY ANNA E. WILLIAMS, Chicago.

Little or nothing was known of the blind until the latter part of the last century, when the great and good Doctor Howe conceived the idea of teaching them to read by touch.

It was a wonderful thought, out of which has grown the state schools for the blind. Every state in the Union now maintains such a school, at which blind pupils are given the usual high-school course. Where the pupils are found to possess musical talent, it may be developed to a surprising degree of excellence.

But, after the school days are over and the pupil leaves the institution with his well-earned diploma in his hand, there still remains unsolved the ever-present problem of "bread winning."

A few trades are taught in the school, among which broom-making and piano-tuning have seemed more promising for the men, and typewriting and fancy work for the



Fig. 1. Weaving department of the Chicago Light House for the Blind.

women. These occupations, however, have proved of little value in the way of actual support. Besides the blind of whom I have been speaking there are those who were deprived of sight at a time of life when school seemed out of the question and when their labor was actually needed to support their families. To these the case seemed hopeless, indeed.

Then the State Industrial Home was established. This consisted of a broom factory and a dormitory where the workmen might reside, if they so desired. They were paid at the rate of a dollar per day for their labor, and, if they lived in the institution, they paid a portion of this sum for their board. The founders of this home were among the more fortunate blind of Chicago, and they were



Fig. 2. Domestic science class of the Chicago Light House for the Blind. Practice teachers are furnished through the courtesy of Lewis Institute.

assisted by their influential, far-seeing friends. It was hoped and believed that the place would soon be self-supporting.

But the institution met with many vicissitudes. The great progressive world moved on at a rapid pace, and the price of material kept pace with all other advancements. Steam machinery and inventions for more rapid production soon succeeded the simpler methods by which the blind had been taught to work. There were times when the factory was closed, because the state appropriation was inadequate to meet its needs. There were times when

the market was dull or the salesmen incompetent, and the factory became overstocked with brooms. There have been rapid changes of administration, because of the changes in politics. The broom-makers, too, fought the factory, and the tide of competition set swift and strong against the blind workman. Through all these years the simplest living had become so great that there seemed but one way to meet it.

Can you picture a sadder sight than the father, gray-haired and blind, standing on the street corner, mutely beseeching alms from the passerby, that he may bring home food to his little ones? Or the blind woman, well educated, delicately bred, possessing all the instincts of refinement, engendered by her early training and environment, lifting up her voice in some pathetic song of home and mother, that, through the medium of music, she may awaken tender memories and thus reach the great, warm, throbbing heart of the mighty throng who are passing constantly, and procure thereby her daily bread?

These things and many more came to the attention of Mrs. C. T. Hood, and she, at the head of a band of good women, began to organize the blind into a society, known as the Improvement Association for the Blind. Mrs. Hood's task was no easy one; there were obstacles to be surmounted, difficulties to be overcome, oppositions to be met and conquered. Still these good women were not dis-



Fig. 3. Glee club of the Improvement Association for Blind People.

couraged. Mrs. Hood and her faithful workers went steadily forward. For, like good gardeners, they had planted the seed of a great work, and they pruned, dug, and watered this plant; they gave it light, air, and sunshine, till it sprang into vigorous life; and they are today rejoicing at its growth. More and more people became interested in the work; more and more of the blind people were drawn into the society, until it has become a recognized organization.

It was then that Mrs. Hood felt the need of a place, a place for our regular meetings, a place where food and clothing might be distributed to the needy, where avenues of employment might be opened for the blind, a social center from which all manner of good might radiate. So a piece of ground containing a small building was purchased. Because of the light it shed over the lives of those who are compelled to struggle onward and upward in the dark, this place has been given the appropriate name of "The Light House."

It is only a year since The Light House was opened, yet the good it has already accomplished can scarcely be estimated. The first object of Mrs. Hood and her associates was to find some remunerative employment for blind women, that they might also assist in the daily struggle for existence. Therefore, five looms for the making of hand-woven rugs were installed in The Light House, and a teacher was employed to instruct the women.

The women are paid at the rate of 25 cents an hour as

soon as their work becomes salable. Rug-weaving has proved itself to be the most profitable occupation yet found for blind women.

But this is not all that The Light House has done. A sewing circle and a chorus class have been organized. Each alternate Sunday an open-door meeting is held, under the direction of Mrs. Hancock. These meetings are devoted entirely to entertainment. Some prominent speaker is invited to address the meeting, after which patriotic and old-time songs are sung. Before the gathering breaks up cake and coffee are served.

Thus, from small beginnings, gigantic enterprises have grown. And we are looking forward to the time when every blind man and woman in the state of Illinois shall be earning an independent living, and when the fame of the Chicago Light House and its work shall have spread throughout the world.

THE FEEBLE-MINDED IN INDUSTRY*

Mental Defectives in Institutions for the Feeble-Minded, in Prisons, and in Society—Need of Scrutinizing the Mentality of Candidates for Employment

BY C. S. ROSS, Industrial Psychologist, Psychiatric Clinic, Sing Sing Prison, Ossining, N. Y.

One of the principal phases of the problem of feeble-mindedness is the relation of the defective individual to industry. What can the mental defective do? What are the results of his attempts to compete with normal individuals? What conditions are most favorable for his maximum industrial production? Without doubt, these are questions deserving careful attention. We shall approach the problem from two different angles, considering, first, the institutional subject and, second, the feeble-minded individual who is at large in the community. In the case of the former, the mental defect has been recognized and a favorable environment has been provided, but the individual at large, with his deficient mentality undetected, is obliged to compete with those better equipped than himself and almost always fails to meet the industrial adjustment possible for those under direct supervision.

In an institution for the feeble-minded, we generally find three distinct types of defectives, namely, the very low-grade feeble-minded case, commonly called the "idiot," the slightly higher type, designated as the "imbecile," and the still higher class, usually known as "moron." In our consideration of industrial relations, we are not concerned with the idiot, since he ordinarily is entirely untrainable, or so defective in motor control that he cannot be made useful and must remain typically a case of dependency. The other two types almost always can be trained to work in some way, unless there is a physical impediment.

On account of the lack of development in the more complex mental processes, as, for instance, reasoning and judgment, it is almost always necessary to adopt motor training in the education of defectives. Although verbal instructions usually make little impression on imbeciles and morons, they are easily stimulated if shown how to perform an act, and their response is, as a rule, quick and fairly satisfactory. By employing motor training, which is based entirely on the imitative response of the individual, it is possible to make them engage in an actual form of serviceable manual labor. The education of the feeble-minded is usually a combination of instruction in

*Author's abstract of a lecture delivered at New York University on February 23, 1917.

elementary school subjects, such as reading, writing, simple arithmetic, etc., and training in some fields of industry, chiefly in those involving manual work. The instruction is gradually made more difficult until the defective proves himself incapable of comprehending more advanced subjects.

It is a well-established fact that the best occupation for the feeble-minded is farm work, the most important reason for this being that farming occupations do not demand a high degree of intelligence. Other reasons are that the environment does not offer the complexity of city conditions, that the men are happier and more contented under the changing routine of rural labor, and that fresh air and outdoor exercise are conducive to good health, which so many of this class lack.

Besides farming, there are, however, many occupations in which the institutional feeble-minded can be trained and in which they can accomplish noteworthy results. Among the industries which are most commonly practiced in the different institutions throughout this country may be mentioned carpentry, basketry, chair-caning, weaving rugs, hammocks, and towels, making rag carpets, making mattresses, chopping wood, making wells, shoemaking, painting, plumbing, printing, sewing, knitting, embroidering, tailoring, laundry work, general housework, and cooking. In some institutions, manicuring is also taught, with the aim of discouraging a prevalent practice among inmates of biting their nails.

At this point an idea suggests itself with regard to the expediency of vocational guidance for the institutional feeble-minded, based on the study of their mental constitutions. Just as it is possible to analyze the mentality of the normal individual and to place him at work in the position for which he is most fitted, so should it be possible also to detect in a feeble-minded individual the inherent characteristics that make him better equipped for one occupation than for another. It is to be hoped that in the future the institutions for mental defectives will make more use of laboratory examinations in assigning the inmate to special work.

The nature of institutions makes it possible to place feeble-minded persons in a favorable environment, and, with proper supervision, to bring about a satisfactory industrial adjustment. However, when the same persons are left to themselves, they are practically incapable of earning a livelihood. As a rule, only from 10 to 15 percent of the inmates discharged ever become absolutely self-supporting.

Let us consider another class of institutional defectives, the feeble-minded individuals who constitute between 20 and 30 percent of our prison population. Nearly all of these unfortunates have engaged at some time or other in economic activity, and most of them have had a career of industrial inefficiency. They all show more or less the same characteristics—lack of a habit of industry, inability to retain a position for a prolonged period, failure to persist in a specific line of work, and want of ambition.

When it comes to the question of prison industry, it is evident that there must be some difficulty in selecting the most suitable trade for these defectives with their history of industrial failure. The psychiatric clinic of Sing Sing Prison is endeavoring to meet the problem by submitting each new inmate to a thorough examination, with the object of determining the subject's mental and physical aptitudes; he is then recommended for the particular type of prison industry for which he seems fitted. An adjustment of labor in this fashion should bring, to the prison, a reduction of waste and an increase in production and, to the

individual, familiarity with a trade which he could pursue after his discharge.

We come next in our discussion to a consideration of the defective individual who is at large in the community and whose deficiency has not yet been detected by society. The majority of these defectives belong to the high-grade class, and they pass unrecognized until continued inefficiency or antisocial conduct demands attention. These high-grade morons are the most capable among the mental defectives of actually earning a livelihood, and we discover them in almost every group of applicants for employment in positions which do not involve special ability. The employment departments connected with industrial concerns are not always prepared to detect them, and one is almost certain of finding employment assigned to a large number of them monthly. As a rule, they are industrially inefficient, except in the very rare instances in which proper supervision is provided and the occupation is of such simple nature that it does not overtax the subject's limited ability.

For the purpose of determining the nature of occupations in which mentally defective individuals engage, we have selected for study 150 adult males diagnosed as feeble-minded, who have been confined in state institutions. In investigating as far as possible the industrial careers of these subjects, we learned the following facts: Of these 150 men, 37 had been common laborers; 22 had done house and hotel work, such as acting as butlers, waiters, cooks, etc.; 20 had worked as chauffeurs, drivers, and teamsters; 7 had been farmers; 22 had worked as shop hands; 5 as rag-pickers and peddlers; 7 as tailors and pressers; 30 had engaged in mechanical trades.

The following data with regard to their mental ages were determined by the application of the Yerkes-Bridges point scale; of these 150 men, 3 possessed a mentality of 7 years; 14 a mentality of 8 years; 29 a mentality of 9 years; 22 a mentality of 10 years; 69 a mentality of 11 years; and 13 a mentality of 12 years.

In correlating the mental ages of these individuals with the types of occupations in which they had engaged, we find that the subjects possessing the highest development of intellectual ability had been engaged in the occupation of chauffeurs, clothing cutters, electricians, nurses, and painters. Most of the subjects having a low-grade intelligence had been working as shop hands, farmers, laundrymen, and peddlers. Of the peddlers, not one had a mentality of over 10 years. For the group of common laborers and the group of factory hands, the average mentality in each case was also 10 years. A fairly high mentality was found among men with trades such as shoemaking, carpentry, and brick-laying.

If we use these statistical data as a basis for a conjecture, we can say that, of the adult mental defectives engaged in economic activities, 15 percent are found doing factory work. In almost every manufacturing concern, we meet cases of intellectual defectiveness, and these are, as a rule, the most costly employees to the factory. They are unsystematic in their methods of work, neglectful, and forgetful of their duties; they show little sense of responsibility, are noted for their lack of punctuality, and evince a readiness to leave their tasks, irrespective of consequences, at the slightest dissatisfaction. On account of this instability, the intellectually defective employee always causes the company an increase in the natural turnover of labor and likewise an increase in the expense of maintenance. It has been estimated that the loss which a company incurs when an employee is discharged or leaves voluntarily

after working for only a short time is about \$30—a conservative estimate.

To give an idea of what the labor turnover means to a company, I wish to quote here the result of an investigation undertaken in one of the manufacturing plants of New York. The conditions in the factory were such that the number of employees discharged monthly was greater than the number of employees actually necessary for carrying on the work of the factory; in other words, to fill one position, often two or more workers had to be engaged and were subsequently discharged in the course of one month. It was found that the factory had for the past year a turnover of 108 percent, while computations showed that the normal turnover for that particular industry should not have exceeded 30 percent. The company had, therefore, an excess turnover of 78 percent, which brought a yearly loss of approximately \$48,000. It would be absurd, of course, to infer that this loss was due wholly to the employment of feeble-minded individuals, but it can be safely stated that, if provision had been made by the company in question to eliminate intellectually inferior workers, the yearly loss would have been greatly reduced.

At the present time, the question of the prevention of accidents in factories is one of the most vital problems in the field of industry. Statistics show that two million men and women are injured in the United States each year in the different industries of the country. The average employer assumes that every employee is a normal individual, but, as a matter of fact, a great number of the workmen engaged in specialized factory labor are incapable of displaying normal judgment and reasoning power. Knowing that there is a large percentage of intellectually defective individuals employed in factory work and sometimes assigned to dangerous occupations, we cannot help feeling that intellectual inferiority is in a great measure responsible for the bulk of accidents in connection with industry.

On account of the increase in the labor turnover, in the number of accidents, and in the amount of faulty work produced when a proportion of the employees in a factory are mentally defective, it is to the advantage of a company to hire only those who are mentally fit for the positions and responsibilities assigned to them. The satisfactory selection of employees would require a comprehensive examination of every applicant for employment, including an investigation into his industrial and medical history, a physical examination, and a psychological test.

Besides being to the advantage of the company, it is to the advantage of the mentally defective individual that every applicant should be subjected to a severe scrutiny in the employment office. If accepted, he is assigned to a position for which he is fitted, or, if rejected, he is spared the useless exertion of trying in vain to meet the exacting requirements of a job from which he would ultimately and necessarily be discharged.

Dr. M. B. Heyman has resigned the superintendency of the Suffolk County Sanatorium, Holtsville, N. Y., to accept the position of assistant superintendent in a New York city hospital.

Mrs. Clara R. Dice, for the last six years superintendent of the Franklin Hospital, Franklin, Pa., has resigned this position to become assistant superintendent of nurses in the Lakeside Hospital, Cleveland, Ohio. Mrs. Dice is a graduate of the Lakeside Hospital and for several years was a nurse in that institution.

THROUGH BRITISH EYES

Sir Henry Burdett's Appreciation of the American Hospital Association and "The Modern Hospital"

In a recent number of his journal, *The Hospital* (London), Sir Henry Burdett gives a discriminating review of American hospital conditions, based on impressions gathered during his recent visit to this country. In the course of an account of the American Hospital Association, he is kind enough to devote some very appreciative words to *THE MODERN HOSPITAL* and its editors. Praise from Sir Hubert—beg pardon—from Sir Henry—is so gratifying that we are going to waive modesty and quote the article entire:

"One of the most remarkable evidences of the spread of efficiency and awakened interest in hospitals, and of developments which aim at extending and improving facilities of all kinds for the training, treatment, uplifting, and restoration of dependents of all types is afforded by the magnificent growth and extended influence for good of the American Hospital Association. In the last twelve years this association has grown from a membership of a few hundreds to one of thousands, and the attendance at its annual conference brings together representatives of all types of institutions, and, through the careful selection of subjects and of the readers of papers to introduce them, it promises soon to become of increasing practical value, directly to the whole of the workers in the American hospital field, and, indirectly, to the whole population of the United States. America prides herself upon being democratic to the core, and it is to the democratic basis on which the American Hospital Association has rested since the Boston meeting in 1906 that the association owes its ever-extending membership and widening interest and influence.

"The establishment of *THE MODERN HOSPITAL*, which has rapidly developed into a monthly magazine, demy quarto in size, containing some 200 pages, of which some 120 contain advertisements and eighty are devoted to literary matter, illustrations, and plans, is a wonderful instance of rapidity of growth in magazine literature. The editors of *THE MODERN HOSPITAL* are Dr. Henry M. Hurd, of the Johns Hopkins Hospital, Baltimore; Dr. Washburn, of the Massachusetts General Hospital, Boston; Dr. Winford H. Smith, Johns Hopkins Hospital; Dr. S. S. Goldwater, Mount Sinai Hospital, New York; Dr. W. L. Babcock, Grace Hospital, Detroit; and Dr. John A. Hornsby, who occupies the editorial offices in Conway Building, Chicago. The editors thus include the best-known and most deservedly trusted of hospital administrators in the United States. Dr. Hornsby is a very influential man, of many parts and excellent qualities. He has a way with him which makes him a model chairman of a large meeting, for he possesses the knack of keeping everybody in the best of humor, and of getting the business through with despatch to the satisfaction of everyone. *THE MODERN HOSPITAL* is to be congratulated upon his occupancy of the editorial chair at its central office.

"The plan of the paper is to devote the space before the leading articles mainly to the history, organization, practical work, plans, with information of many kinds relating to hospitals and institutions for the relief and treatment of disease in all its aspects. Some four pages are devoted to editorials. Ample space is given to every branch of hospital work, including the remodeling of a hospital, electricity as applied to hospitals, tuberculosis in every form and under varied conditions, current hospital literature (a strong and excellent department), and a Department of Nursing conducted by Miss Annie W. Goodrich, a most devoted and able worker, and knowledgeable, too. Then there are an immensity of special subjects, including Maternity, the Modern Sanatorium, Social Hygiene, Foreign Correspondence, a Department of Dietetics, Industrial Welfare, Queries and Answers, the Bulletin of the American Hospital Association, Book Reviews, New Instruments and Equipments, and news of the hospital field in short paragraphs spread over many of the advertisement pages.

"We hope that the removal of the editorial department to new and more suitable offices, and the increase in the staff, will, with Dr. Hornsby's usual energetic and prac-

tical assistance, speedily result in all plans published in THE MODERN HOSPITAL being reduced to scale, on the plan pursued by *The Hospital* for over thirty years. It would be a very pleasant and helpful thing if our brother editor were to join hands with us by making this change, for that would make the files of THE MODERN HOSPITAL with those of *The Hospital* indispensable to every architect associated with hospital construction. The educational effect and value which would follow cannot be exaggerated. We may take this opportunity to express our personal indebtedness for the great courtesy and help extended to us by Dr. Hornsby and the President of THE MODERN HOSPITAL during our visit to the United States last fall. Nothing could exceed their courtesy, and gratitude makes us hope that they may give us an opportunity one day to welcome them to the Old Country, and to do what we can to add to the enjoyment and practical value of their enterprise by every means in our power."

FATHER OF EUGENICS

Mendel the Monk, Working With a Pea, Pointed the Way to Better Offspring—Discovered Laws of Heredity

Gregor Mendel, peasant boy, monk and abbot of Brunn, an experimental botanist whose work in his cloister garden laid the foundation of that exact knowledge of heredity which is now being extended in many directions, was born July 22, 1822.

He died in 1882. Eighteen years later began the appreciation of his labors. His doctrines, which are called mendelism, form the scientific basis of the science of eugenics, "the science of being well born." Mendel's work made it possible for us to predict with precision whether good or bad traits will or will not appear in future offspring and to forecast with mathematical accuracy the proportion in which certain characteristics will appear and reappear.

This is important to the public health because defective persons breed defective persons, and an increased knowledge of heredity means an increased power in the prevention of the creation of degenerate and insane persons on the one hand and normal, efficient people on the other.

The population of the United States increased about 11 percent between 1904 and 1910, while the number of persons in insane asylums during the same period increased 25 percent. A single family of defectives cost the state of New York in five generations over one million and a quarter dollars.

When it is realized that not only mental but also physical traits, such as deaf-mutism, color-blindness, gout, shortsightedness, alcoholism, epilepsy, imbecility, and insanity may all be transmitted to offspring, the importance of Mendel's work to the public health and public pocket-book is readily seen.

The prevention of the propagation of defectives may be controlled by the education of parents so that they will endeavor to prevent a union of their children with children of defective families; legislation requiring a medical certificate of parties applying for marriage licenses; and surgery which aims to render defectives incapable of procreating. Indiana, Wisconsin, and California have laws permitting such operations.

The segregation of defectives has not proved practicable; in fact, in the case of the deaf and dumb, it serves to increase rather than to decrease their number.

Mendel's experiments were made with the common pea, but the principles which he deduced from his studies are applicable not only to mankind, but also to all of the lower animals, and are hence of importance to the public health worker, the botanist, and the agriculturist.

ANTITUBERCULOSIS WORK IN A SMALL CITY

Educational Work Through Local Organization—Visiting Nurses and Day Camp for Children Important Factors

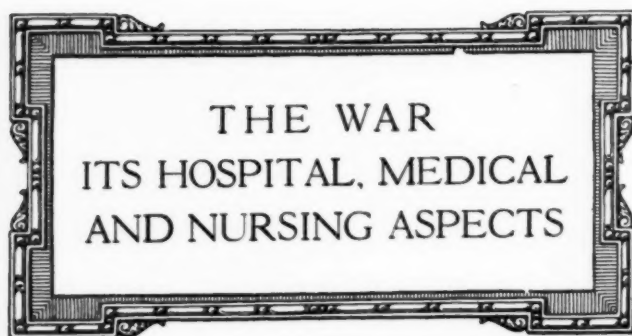
Dr. Frank C. Neal, of Peterboro, Ontario, describes in the *Canadian Medical Association Journal* an antituberculosis campaign in a small Canadian city without a tuberculosis sanatorium or clinic. A few persons who were interested in antituberculosis work in 1911 formed the Peterboro Health Association, which became affiliated with the Canadian Association for the Prevention of Tuberculosis. Through the distribution of literature, public meetings, and outside and local speakers, an interest was aroused, and through a fair, with sale of health calendars and Christmas stamps, a sum of over \$4,000 was realized. A tuberculosis nurse was then engaged, but a year's trial convinced the association that one nurse was not enough, particularly as that one was devoted exclusively to tuberculosis. Many persons would do without the tuberculosis nurse's care rather than allow the neighbors to infer from her attendance the fact that tuberculosis existed in their homes. A nurse doing general work would, it was thought, more easily gain admittance. Moreover, the duty of the tuberculosis nurse being to attend only to cases of that disease, she was compelled to pass by cases of other diseases which were just as urgently in need of nursing care. A nurse doing general nursing would therefore be able to report many cases of tuberculosis which otherwise would be overlooked.

Accordingly the association was reorganized. An increased membership with a small yearly fee was sought. Finance, educational, and supervision committees were appointed, the finance committee receiving a grant of \$50 a month from the city council for the purchase of supplies for needy patients. A second nurse was appointed to cooperate with the first. Since many cases of disease in children were still not reached, the board of education appointed a school nurse, and very satisfactory cooperation developed among the medical health officer, the school nurse, and the health association.

In 1914 a day camp was established for children with inactive, incipient tuberculosis, contact cases, and underdeveloped, poorly nourished children. The site of the camp was a large natural park through which runs a creek. A trained nurse was in attendance to care for the children, and a cook to prepare the food. A bus called for the children at their homes in the morning. At the camp, on their arrival, they were given a light lunch and then allowed to play about for a couple of hours. At noon a nourishing, substantial dinner was served, and then the children rested or slept for two hours on cots in a huge tent. Then they were allowed to play again until time for their afternoon lunch, after which they were taken home in the bus.

The camp was suspended at the outbreak of the war, but the association expects to reopen it, and also to establish open-air rooms in the schools.

The Plainview General Hospital is a new institution at Plainview, Neb., offering accommodations to 10 patients at a time, with a possible capacity of 15. The building, with its equipment, cost \$15,000 and is the result of a campaign conducted last fall by local business men and physicians to impress upon the people the need and advantages of a community hospital. Dr. Melerian, a member of the board of trustees, has donated equipment for an x-ray room. Dr. Melerian will be general superintendent of the hospital.



THE FIRST RED CROSS "RECONSTRUCTION HOSPITAL" IN THIS COUNTRY

Extensive New Jersey Estate Donated for the Use of Convalescents From War Injuries—Orthopedic and Reeducational Work to Fit Cripples for Self-Support

Elsewhere in this issue we publish the first installment of an article on the work of the Military Hospitals Commission of Canada in the "reconstruction" of war wrecks. The orthopedic treatment and functional and vocational reeducation of crippled soldiers is one of the most important branches of war relief. This is one of the departments in which we, too, must prepare speedily to meet what is before us.

The United States will have three "reconstruction hospitals" under the control of the Red Cross, where wounded men may be, as far as possible, restored to health and usefulness. The first of these has been fitted up by Dr. Fred H. Albee on the New Jersey estate of Mr. and Mrs. Charles D. Freeman, which they have donated for the purpose. The site, an ideal one, is on the Pennsylvania Railroad. The large house, built on high ground, looks out on woods and pleasant fields. Through the center runs a great hall, two stories high, 35 feet wide, and 65 feet long, with a gallery opening on it from the second floor. The x-ray and operating rooms are on the second floor, which has not required alteration for the purpose. A piazza 100 feet long runs along one side of the house, and its roof forms a balcony on which the second-floor rooms on that side open. Patients who are well enough to be moved may be wheeled out on the broad piazza or the balcony above. It is estimated that 500 patients can be cared for in the hospital, and that, if necessary, the capacity can be increased to 2,000.

Dr. Albee spent three months last year inspecting base hospitals in France. His conclusions as to the requirements for an ideal orthopedic base hospital (all of which requirements are met by the Freeman estate) are enumerated as follows in a recent number of the *New York Medical Journal*:

The site should be in the country, away from city noise and confusion, but accessible to transportation and to gas, electricity, and water mains. The elevation should be sufficient to insure good drainage, and the acreage extensive enough to allow of expansion. The main building must be spacious and the beds so arranged that each patient receives adequate air, with many large windows and ample veranda space onto which chairs and beds may be wheeled. The hospital must have modern, up-to-date equipment, including a traction fracture table, adjustable superstructures to go over beds, controlled by traction with pulleys, weights, counterweights, etc., in the position of neutral muscle pull for fractures, an outfit for supplying Carrel-

Dakin solution to wounds, a thoroughly up-to-date x-ray equipment with a localization outfit for the detection of foreign bodies, a Zander apparatus room, and a supply of various materials, such as plaster-of-paris, steel, aluminum, aluminum bronze, Monell metal for making splints, braces, etc. A large athletic field, and a factory for making braces and artificial limbs are also important features. The staff of the reeducational department should include specialists in psychotherapy and muscle training.

* * * *

PLANS FOR NEW ARMY HOSPITALS

Outline of Provision Made by the Medical Department of the Army for Care of New Forces at Home and Abroad

The medical department of the army has announced that \$14,500,000 would be expended in the construction of thirty-two new army hospitals. Hospital provision will be made in the United States for 5 percent of the enlisted force by the early fall, and this will be gradually extended to 10 percent. Facilities will be provided in Europe for 20 percent of any expeditionary force which may be sent over. At the cantonments in the United States, hospitals will be provided to care for 3 percent of the troops to be assigned to each camp. The standard adopted will be a thousand-bed hospital. Such a hospital with its various subsidiary buildings will require sixty acres and will cost about \$500,000, inclusive of heating plants.

Each hospital will have equipment equal to that of the best institutions in the country, although the construction of the buildings will be of much cheaper quality. One type is being used for all the construction work. All the buildings are twenty-four feet wide, the length varying to meet the needs. The wards are usually 157 feet long, which is the size needed for thirty-two beds.

There will be a diet kitchen for each ward, a porch on one side and end of each ward, and a corridor connecting with the buildings on either side, which will be covered in the case of northern cantonments. About seventy buildings will be comprised in each cantonment hospital on the thousand-bed basis. In some cases two wards are joined, reducing the actual number of separate buildings, but the number of buildings will reach about seventy, counting each ward as a building.

Each hospital will have a laboratory for bacteriological and pathological work. Some special blood tests will be made at the department hospitals, which will take care of any work that the divisional hospitals at the camps cannot attend to. There will also be an infirmary for each regiment. There men not needing to be confined in hospital will report, when any condition appears which demands watching, and vaccination will be done, and the typhoid and paratyphoid preventive treatments administered.

There will be nearly 400,000 men in the National Guard camps and 500,000 in the national army cantonments—an army of nearly 1,000,000 exclusive of the regulars. Plans have been made for enlarging some of thirty hospitals used in connection with the officers' training camps. Two general hospitals at ports are being taken over by the army. Two other general hospitals are being enlarged behind these, and a number of general hospitals are being taken over or built for special treatment work. Plans for the latter phase of the work are not complete. It is announced that steps were being taken to work out plans for reconstruction hospitals, where artificial limbs will be made and fitted, repair surgery done, and the reeducation

of cripples begun to enable them to use the artificial limbs.

Each man in the new armies will have the equivalent of six or more examinations by specialists, in addition to the regular examinations as to general health condition. Leading specialists are now working out plans and personnel for the special examination work at each hospital. Every man will be examined for tuberculosis, affections of the heart, foot trouble, ear, throat, and nose diseases, hookworm and other intestinal infections, and for typhoid, paratyphoid, and other disease carriers.

* * * *

BATHING FACILITIES FOR SOLDIERS AT THE FRONT

Methods Used in the Armies of the Various Nations in the Present War to Keep Soldiers Clean and Healthy

The bathing habits of soldiers in the United States army are good, and there are no special problems to be solved with regard to the bathing facilities of our soldiers in barracks or in camps during peace times, says Lieut.-Col. C. C. McCulloch, professor of military hygiene in the Army Medical School, writing in a recent issue of the *Southern Medical Journal*. On the other hand, the Spanish-American war teaches that untrained troops suddenly placed in the field often neglect the simplest rules of hygiene. Since this country has had no experience with the mobilization of very large bodies of troops later than the Civil War, it is important to study the methods adopted in foreign armies during the present war.

The Russians, Colonel McCulloch says, were the first to attempt the solution of the problem of bathing troops by wholesale, and have apparently paid most attention to it. The bath trains said to be operated by the Russian army are invaluable within their sphere of operation. The "hut method," also used by the Russians, makes use of a peasant's hut, preferably with two rooms, one being used for dressing. The bath room is heated by iron stoves and serpentine stove pipes, over which, when heated red hot, water is poured. The linen is boiled, dried, and mended while the men are bathing, for, owing to the prevalence of typhus, the disinfection of clothing is as necessary as the bathing of the men. About 700 men can be bathed a day in such a hut. The main objection to the method is that the men are not handled with sufficient rapidity.

A substitute for this method is the pit shower bath devised by a French physician. A pit about 20 feet in diameter is paved with brick and roofed with sheet iron covered with sodded earth. On the roof is placed a boiler and a large tub with four outlets controlled by stopcocks, each outlet communicating through the roof with a sprinkler under which is placed a tub.

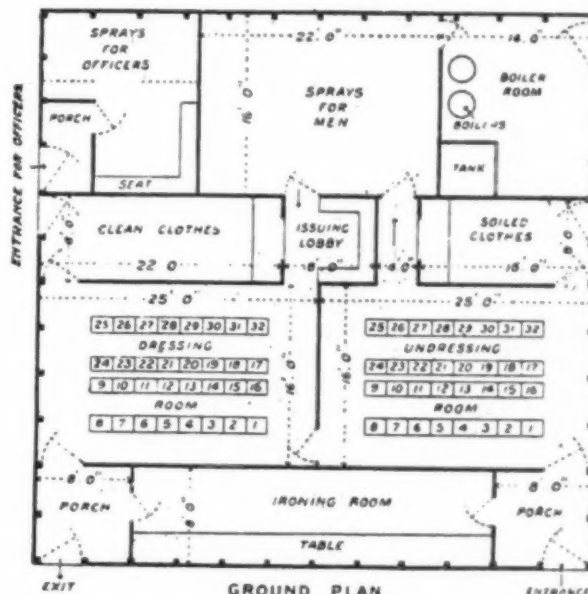
The traveling bath of the sanitary detachment of the Eighteenth Army Corps is said to have the following advantageous features: 1. While bathing, the men have their hair cut and their clothing and linen disinfected and freed from insects. 2. One hundred men can be bathed in an hour. 3. Those who have bathed do not come in contact with those who have not. 4. The waste water is run off from the floor into disconnectable gutters by which it is removed. 5. The bath is easily movable and can be set up in any convenient place. 6. The floor of the bathing pavilion is heated.

The installation consists, in the first place, of a large circular tent, about 23 yards in diameter, in the center of which is a smaller tent, the bath proper, the space between the two tents being divided into two circular corridors by a circular canvas wall suspended on uprights. The ex-

ternal corridor contains the anterooms of the disrobing chamber and the dressing chamber, the sterilization room and the laundry. The internal corridor contains the undressing chamber, the barber shop, the distributing room for soap and bast wisps, with a door leading into the bathing tent, and the dressing room, with doors leading out, partitioned off from the undressing and distributing rooms. The central bathing tent is floored with corrugated sheet iron inclined toward the center, water being run off by a gutter in the middle. On the surface of this iron floor and in the anterooms is placed a light wooden grating. The corridor floors are heated by iron stoves with stovepipes laid under the grating and finally out through asbestos-lined opening in the roof. The bathing tent is heated by the water-heater.

The bath can be set up and prepared for operation in three or four hours and can be dismantled and removed in less than an hour. A Russian regiment of 4,000 or 4,500 men can be bathed in two days or less by this method.

A less elaborate and expensive plan is that of the demountable transportable shower baths of the French Serv-



Portable frame bath building devised for use by English troops in the field.

ice of Coordination of Voluntary Aid for Soldiers. This costs about \$100, weighs about 330 pounds, and serves from 250 to 500 bathers, according to the number of showers installed, per working day of six hours. It has given satisfaction in the field. Its disadvantages are the comparatively small capacity and the difficulty of adapting it to winter conditions.

The Russian bath trains consist each of twenty baggage cars adapted to the purpose. The locomotive is furnished with a supplementary boiler for heating the bath water and a steam pump for supplying the showers. Two tank cars at the head of the train contain water enough for twenty-four hours' use. Following are undressing cars, bathing cars, cars provided with couches where the men may rest after bathing; restaurant cars, dressing cars, and cars arranged for use as disinfecting chambers; kitchens, storerooms, quarters for the personnel, a shoemaker shop, a mending room, and even a barber shop. Each train can bathe, disinfect, and feed from two three thousand soldiers daily. The cost, exclusive of the locomotive, is about \$50,000 for each train, and the cost of maintenance is

\$5,000 a month, exclusive of new linen. Dr. McCulloch confesses to some skepticism concerning the scheme, although it is vouched for by a reliable French author. Similar but simpler and cheaper trains have been proposed for use in the German army, and perhaps have been put into use.

The latest English methods for bathing soldiers in the field, described by Capt. H. N. Goode in the *Journal of the Royal Army Medical Corps* for September, 1916, also pay regard to the principle of separation of soiled and clean parts. The accompanying plan shows a portable frame bath building devised by Captain Goode.

* * * *

AMERICAN GIRLS SERVING THE CAUSE IN FRANCE*

The Motor Service of the American Fund for French Wounded and Its "Wonderful Chauffeuses"

Long before the entry of this country into the war, the organization known as the American Fund for French Wounded had been instrumental in relieving the sufferings of tens of thousands of wounded. Bandages, medical and surgical supplies, clothing, etc., have been given by Americans and distributed, from centers established in Paris, at Nice, Pau, Chambéry, and at other points, to the various hospitals all over France. Perhaps the most remarkable feature of the work is the transport service, maintained by

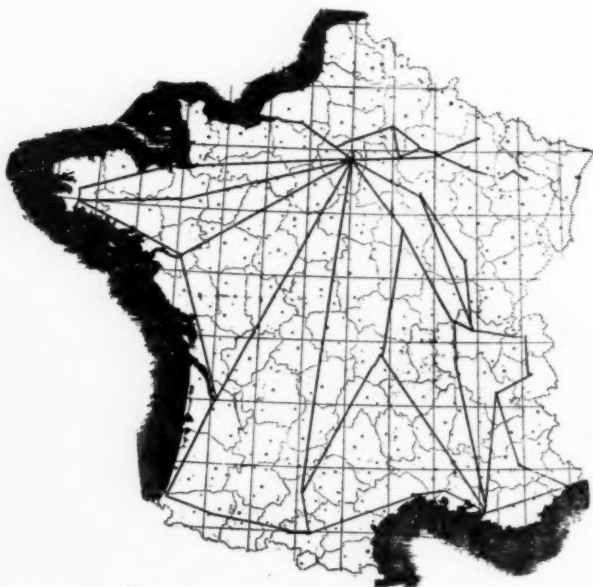


Fig. 1. Extent of French territory covered by the motor service of the American Fund for French Wounded, shown by black lines radiating from Paris.

special donations and operated by American girl volunteers, many of whom, we are told, not only give all their time to the work, but also pay for the maintenance of the cars which they drive.

No holiday service is theirs. Not only do the girls drive over all kinds of roads and in all weathers; they must also look after the repairs and cleaning and even pack, load, and unload the cars with such trifles as fifty-pound crates, boxes and bundles. Hardships and vicissitudes in plenty are the lot of these plucky workers, but it is said that nothing very serious has ever interfered with their efforts. A fire in the engine—a breakdown an hour before mid-

night on the roads, fifty miles out of Paris—an accident averted by hasty jamming down the brakes, which inflicted minor injuries on car and chauffeuse—such incidents as these (described in the Monthly Report of the A. F. F. W.) are all in the day's work. The way in which the routes of these chauffeuses of the A. F. F. W. have covered France is shown in the map (Fig. 1).



Fig. 2. "Boston" (a truck so called because given and supported by the Boston committee) develops engine trouble. The cars are affectionately known as "George," "Lizzie," "Eddy," "St. Paul," "Magnolia," and "San Francisco."

The life of one of these girl workers is well sketched in the letters from one of them, Miss Theodora Dunham, published in the August number of the *Red Cross Magazine*.

"Perhaps," says Miss Dunham, "you would like to hear of a day's work as chauffeur."

"Well, every morning I am over at the garage before eight, getting the key from the funny old concierge, throwing open the big wooden doors, and running out the cars to the water pipe for a very decrepit old man to wash. Then I run to the apartment for some breakfast, and am back by 8:30 to see how he has gotten along. The washing is a hasty affair, and only makes the upper part of the car a little more respectable; the real cleaning remains for us to do on Saturdays. There is always the inside of the car to be brushed out, gasoline to be put in the tank—by the way, it is a dollar a *bidon* (a *bidon* being only very little more than a gallon) now—the engine to be oiled and looked over and the radiator filled before we start off for headquarters. It's a splendid feeling to be driving your own truck down Raspail, and I thrill with pride when I cross the Place de la Concorde and look up the Champs Elysées to the Arc de Triomphe looking down at me.

The morning is taken up with errands, usually, bales of old clothes to be sent to some *vestiere*, or the doctor of the Fund to be taken to investigate some hospital. Then comes an hour off for lunch, which we usually spend at Duvals thoroughly enjoying a mutton stew, followed by a *petit suisse* and *confiture*. At two, all hands are back at work and we motor-drivers dash upstairs to find out what delivery has been assigned to us. There are cases to be delivered to hospitals in Paris, and also to those in Versailles and other places an hour's ride from the city. Of course the out-of-town deliveries are the most interesting."

Then, of the items in the necessary drudgery, she writes:

"It's a most annoying job to wash a car. Oh, the slop and the mess don't matter if only it would get clean! You go all over it with the hose, then scrub it with a brush until all the mud is off, one last washing with the hose and the car looks shiny and clean. But wait until it dries—all

*Figs. 2, 3, 4, and 5 are presented here by courtesy of the Red Cross Magazine.

the dirt that you were so sure was off reappears and the car is almost more of a sight than when you started! A good washing takes almost all morning. Then there are the twenty-seven grease cups to be filled, perhaps a fan belt to be tightened, spark plugs to be cleaned, and the whole engine wiped off. Sometimes there is an old tire to be gotten off a rusty rim, and that means

covers of knotted silk. But for the most part the men in bed just lie there. The men on crutches lounge around, smoke and talk to each other. You can imagine, when you take into consideration that so many of the buildings are old and the walls a dingy gray, how depressing it is to be in them day after day and month after month, with horrible memories behind you, and nothing to look for-



Fig. 3. Stalled in a snowbank—one of the incidents that keep the life of the American chauffeurs from growing monotonous.

an all day's work with another driver or two to help. It's strenuous work, but it's fun to laugh at a fellow-worker in overalls, with greasy, black hands, and a smutch across her face, crawling out after an hour's work underneath her car!"

From Chambéry she writes:

"Since we have been down here I have had the chance to visit the hospitals, talk with the men and stay a little while, and have realized more than I ever did before, the

ward to but another turn in the trenches, another wound, the same months in the hospital, everything all over again—or else a return to a family that is struggling to keep alive, a return probably not to help, but to be a burden.

"My job as chauffeur is not a strenuous one. There are nine hospitals here, all within two blocks of each other, so that I no sooner get on high speed than I have to stop, jump out, send a saluting military gentleman to find the infirmière majeure, and when that personage arrives



Fig. 4. Owing to lack of other labor, the girls often have to load and unload their own cars. The uniform worn by the girls in the picture is of dark blue. The military jacket is fastened with Red Cross buttons. Round the waist is worn a black leather belt, and an additional military touch is given by blue cloth epaulets bearing the letters "A. F. F. W."

gloomy, depressing monotony of hospital life. . . . Usually you do find one or two games of checkers, or a pack of filthy cards to a hospital, and two or three times I have seen men stringing beads and making hideous table



Fig. 5. Miss Dunham having her first experience as an ambulancière. "They gave me another blessé," she says. "As they were taking him out his coat fell back and I saw the Croix de Guerre and the Médaille Militaire on his breast."

make my little speech, 'Bon jour, Ma Mere or Ma Soeur or just plain Madame. J'ai trois caisses pour vous de la part du Comité Américain. (I have three boxes for you from the American Committee), etc.' Then I am usually clasped by both hands, sometimes kissed on both cheeks

and taken upstairs where clothes of every description are unpacked and admired. The other day I even drank a glass of liquor with ma soeur Chlorinde up at the hospice civile!

"The poilu is a most grateful and simple person. If you pass him a box full of cigarettes, he has to be strongly urged before he will take more than one. He is usually shy, but loves to talk about his family, or any other subject, whenever you get him started. As for the work that we do over here, to him it is always *magnifique*. In each hospital either the *médecin chef*, or one of the leaders among the men, makes us a little speech, and the way a Frenchman can express in one sentence his feelings of gratitude and friendship, the ideals for which he is fighting, and we are working, and all the sympathy there is between us, is, to me, a continual marvel."

* * * *

THE REHABILITATION OF WOUNDED CANADIAN SOLDIERS*

Work of the Military Hospitals Commission of Canada in Restoring Functions of Injured Soldiers

DISCHARGE DEPOTS

There are three discharge depots for returning soldiers at the three chief ports in eastern Canada, Quebec, Halifax, and St. John. The submarine situation and other considerations have caused frequent changes in admiralty plans regarding the delivery of hospital and transport ships, so the Military Hospitals Commission is prepared to meet arrivals at all three places. At present most of the ships arrive at Halifax, but convenience in distributing has made Quebec the real clearing hospital.

Of shiploads arriving at Halifax, all cases for Prince Edward Island, Nova Scotia, and New Brunswick are cleared at Pier 2, where a former immigration building has been remodeled, redecorated, and converted into a well-appointed hospital. All other cases are sent to Quebec by special train, attached to which are hospital cars for bed cases.

At Quebec, as at Halifax, it is the immigration department's wharf that the commission is using as a clearing hospital, Canada's only immigrants these days being her own sons returning from that new and ever-widening frontier of the Dominion "somewhere in France."

The Quebec Discharge Depot has been very extensively remodeled, runways from the boat landing, elevators, modern kitchen equipment and serving conveniences, solarium for tuberculosis cases, and isolation wards for infectious diseases and nervous cases having been provided.

In St. John 100 beds are in use in the Bank of Montreal building, close to the wharf, and a modern 450-bed hospital has been created out of the former armories. The admiralty has made fewer deliveries at St. John in recent months than at either of the other ports. The armories clearing hospital has not yet been used, but nobody can predict when it will suddenly be required.

All returned soldiers are interviewed, passed upon by a medical board, and forwarded to their proper destinations, usually the nearest hospital to their former place of residence. The boards divide the men into three classes: (1) men for immediate discharge without pension, unfit for overseas service, but capable of returning to their previous civilian occupation, or with disabilities neither the result of service nor aggravated by it; (2) men whose condition may be benefited by further medical treatment; (3) men with permanent disability who will not be benefited by fur-

ther treatment and whose cases come before the board of pension commissioners.

About 70 percent of cases returning at the present time are boarded to Class 2, although at first the percentage was very little over 50. Probably at that time the possibilities of restoration were not recognized to be so great as they are now known to be, but an additional reason is that as hospital accommodation in England becomes more and more taxed the proportion of active treatment cases sent to Canada is increasing. Class 2 men are those in whom the Military Hospitals Commission is concerned. At the discharge depot their medical history sheets are filled out in elaborate detail and copies are forwarded to the hospitals to which the men are bound as a guide to the medical officers who will have to treat them. Recording officers also interview the arrivals and obtain from them information regarding their previous education, occupation, technical accomplishments, disabilities, etc., as a guide to the vocational training officers and employment bureaus whose duty it will be to assist them in getting a footing in civilian life again. It is not usual for men to be kept at the discharge depots longer than four or five days, as even a large shipload can be boarded and recorded within that time. Some of the men may leave within twenty-four hours of their arrival in port.

CARING FOR INCURABLES

Early in 1917 the Military Hospitals Commission decided that it was necessary to open a permanent home for incurable soldiers, odd cases which would be admissible having been drawn to official attention. A very splendid offer was made by the estate of the late Mrs. Lillian Massey-Treble of her former residence, in one of the chief residential avenues of Toronto, for this purpose. Instructions were sent to all medical officers throughout the Dominion to make a survey of the cases under their care and to report the number requiring treatment in a permanent home for incurables. It took several months of careful study before final returns were complete. One of the most optimistic facts in connection with the whole returned soldier question is that, although about 17,000 wounded have been returned to Canada already, only 37 were reported as eligible for admission to this home. Undoubtedly not all of the 37 will reach the home for incurables, as some of them come from wealthy families who will be glad to assume responsibility for their sons' care in their own homes.

By incurables in this sense are meant paralytics chiefly, some very mild epileptics, and other miscellaneous types from which, of course, chronic mental and nervous cases and tuberculous cases are excluded. The situation in regard to these other cases, however, is equally cheerful. In provincial hospitals for the insane there are now 46 returned soldiers, and in the commission's special institutions for nervous patients there are 40 chronic cases, making a total of 86 cases for whose recovery little hope is held. Of the tuberculosis cases being cared for by the Military Hospitals Commission, only 89 are incurable, although about 1,200 cases have been returned to Canada or passed over to the commission from military camps in the Dominion. There are nine totally blind returned soldiers and three who are going blind. Amputations are, in the one sense, of course, incurable, inasmuch as a leg or arm cannot be made to grow again, but of these even there are only 512 on the books of the commission. Canada's casualties have long since passed the hundred thousand mark, so that when these figures are compared with 17,000 of the ones so seriously wounded that they had to be returned to

*This article has been prepared under the auspices of the Military Hospitals Commission of Canada in response to a request from THE MODERN HOSPITAL.

Canada as unfit for further fighting service, fairly good insight into the situation is given.

The home for miscellaneous incurables is capable of accommodating 40 beds, and apparently that is as many as will be needed for a long time to come. A rather somber beauty characterized the rich, but dark-hued interior decorations of many rooms of the house when taken over, but the commission redecorated along its usual lines, substituting cream and pale blue tints. A lovely garden, a sun room, one of the best-stocked private conservatories in Toronto, and a \$15,000 combination pipe organ and player piano are features of the home which will make the life of the inmates as cheerful as can be expected in the circumstances. Orderlies and male help will live in the coach house, the third story of the dwelling being reserved for nurses and the dietitian.

The class of scientific equipment and apparatus required to alleviate the suffering of the patients will depend entirely upon individual needs. It has not been the policy of the government to stint itself in this direction.

The proportion of nurses to patients in this hospital will be very high in comparison with the homes for convalescents, as the patients will be almost completely helpless and will require a great deal of personal attention.

NERVOUS AND MENTAL CASES

Great interest has been shown in the number of nervous and mental cases returning from the front. Wild stories have appeared in print on various occasions about men going insane under the terrific strain of the modern battlefield, and there is an impression about that hundreds and thousands of men are returning from the front mental wrecks. This happily is quite inaccurate. Various medical officers who have returned from the front, when interviewed by the writer on this point, stated that they never had heard of a specific case of a man going insane on the battlefield. The number of patients of this class for whom the Military Hospitals Commission of Canada has had to care bears out this testimony. Among the 17,000 Canadian soldiers who have returned from overseas, mental and nervous symptoms of some sort have been diagnosed in about 1,500 cases. An analysis of the 644 men in this class who returned during the first four months of 1917 shows that 72 percent of the cases were caused or aggravated by service, but the chronic cases are not within that 72 percent. Of the 644 men, 380, or 58 percent, were nervous types caused by service. These will all recover under proper treatment in suitable surroundings. In 91 cases, or 14 percent, there were nervous symptoms caused by gunshot wounds in the head. This, of course, was caused by service, and little hope for removal of the symptoms is given. Of mental cases, including insanity and feeble-mindedness, there were 97, or 16 percent. These are not caused by service and usually the symptoms became obvious long before the men got near the firing line. Although no accurate report has been made on the subject, medical officers who have had to deal with these mental cases assert that few, if any, have been in action. Epilepsy and allied conditions (fits) account for 54 men, or 8 percent, and these conditions are not caused by service. There are 22 men, or 4 percent, suffering from organic diseases of the nervous system, likewise not caused by service.

Viewing the statistics just given, it is observed that of the 72 percent of nervous and mental cases caused by service, only those suffering from head injuries will not progress to ultimate recovery under treatment. It is estimated that three out of every thousand persons of ordinary

population are insane. Various efforts have been made to arrive at the figures among army casualties, and, strange as it may seem at first glance, all statistical efforts to get at this result show a smaller proportion, or about 1½ to every thousand. The fact that a medical examination had to be passed before admission to the army contributes to the smaller average, and the reason there are any insanity cases at all is said to be the power of the army to draw so many youths who are really mental defectives.

The Military Hospitals Commission at first did not consider it necessary to segregate nervous and mental cases, but mixed the two in the Ontario Military Hospital at Cobourg, a former college building capable of accommodating about 140 patients. As the work developed it was decided to make the Cobourg place purely a hospital for the treatment of shell shock, and another college building at Newmarket was acquired through the patriotic gift of the religious Society of Friends, which will ultimately be the center for those suffering from mental troubles.

At Cobourg the Military Hospitals Commission is erecting four of its standard 75-bed convalescent wards in two two-story wings. This will make accommodation for close to 450 patients. A staff of nerve specialists will conduct the medical work, while at Newmarket, where the accommodation does not exceed about 150, alienists will be in charge.

By publicity and other methods the commission is seeking to remove completely from the Cobourg institution all suggestion of its being a hospital for the insane for the sake of the psychological effect on the patients and their families. The institution is called the Ontario Military Convalescent Hospital. Its work is purely convalescent. Chronic cases will be cared for either at Newmarket or in the existing provincial hospitals for the insane.

[To be continued.]

* * * *

Camel Transport for the Wounded

"The ship of the desert" has been brought into use in the transport of the sick and wounded and trained for ambulance work in our Eastern campaign," says the *British Journal of Nursing*. "The camel in our illus-



From the *British Journal of Nursing*.
A camel ambulance.

tration is seen carrying on stretchers two wounded 'Tom-mies,' who balance one another. High in the air as they appear, it will be remembered that the camel kneels to receive its burden, and then rises and strides away, covering the ground at a great pace, with a swaying movement which causes some people to suffer from sickness-akin to seasickness."



Conducted by MISS ANNIE W. GOODRICH.
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Please address items of news and inquiries regarding Department of Nursing to the editor of this department, Teachers' College, Columbia University, New York City.

Administrative and Legislative Problems in Meeting Modern Demands on the Graduate Nurse*

BY ANNA C. JAMME, R. N., Director Bureau of Registration of Nurses, California State Board of Health.

In this problem of meeting demands of modern society, from both the educational and the practical standpoint, ours is not an isolated position, but parallels what is today before general educators. Like them, we must admit that there is a rapidly changing order in our social economy which is transposing social organization and producing its influence on education in general, even including nursing education. Mr. David Snedden, in the opening chapters of his book, "Problems of Educational Readjustment," affirms that there is a new education in the same sense that there is a new industrial order, a new practice of medicine, and a new philanthropy, which owes its origin to the development of scientific knowledge and to the spread of democratic ideals. Science has revolutionized nursing as it has revolutionized medicine, agriculture, and warfare, and is bringing with it a new education, which requires readjustment.

Hitherto nursing has rested on a foundation built upon the theory of cure rather than upon the theory of prevention of disease. Largely, the scheme for the training and education of the nurse has prepared her for bedside work and for nursing in the home after her graduation. Although this ideal cannot now, and probably never will, be entirely abandoned, for the nurse's function in the actual care of the sick at the bedside can never be withheld, even in changing modern sociological conditions, yet sufficient progress has been made in the evolution of nursing to convince nearly all careful students of the demand for a more purposeful, a more comprehensive, and, if I may say so, a more efficient system of preparing our student nurses in our undergraduate schools. Forces outside the field of the training school are compelling this reconstruction, both in the aim and in the methods of teaching.

As for the basic administrative consideration, this is doubtless concerned with the educational program to be carried out in our schools of nursing. The readjustment of the curriculum, giving an arrangement that will find place in the latter part of the third year for the study of sociological and community problems, may be a primary consideration. The scope of nursing education will, to a certain extent, have to be defined in terms of social economy and will have to embrace studies and practices which will deal with the practical problems of reducing suffering

and waste of human life, and also the conditions which give rise to disease and moral delinquency.

Initiation of this idea has already been made, as has been demonstrated in several cities, where the nurses of the senior classes cooperated for the purpose of instruction in subjects relating especially to community welfare. It cannot be said that in any one of these courses sufficient insight has been given to prepare a nurse actually to practice a specialty, but it has served the purpose of opening the vision of the students and showing how the work of the training school should be linked with the work in the community. Even if the student never enters into post-graduate study, she is made richer in measure than if she never had had this instruction. This has been an important step in socializing our schools, also in advancing toward more uniformity of ideals amongst students, and foreshadows greater developments as our educational vision enlarges.

Heretofore the curriculum has been rigid and the student has had only a limited power of selection or none. Opportunity to show initiative or self-direction has not been her privilege. Granted that her vision should be faulty and her election not what she eventually follows, does she not gain in the very fact of exercising her power of initiative? We should, in my opinion, consider making the curriculum of the last six months of the course sufficiently flexible to fit the needs of different groups of students who will have sufficient purpose in their training to desire some special instruction in subjects that will aid them in meeting the various requirements that will come after graduation.

I do not wish the idea of election in the third year to be confused with the idea of specialization. I consider that a specialty can be taught only in a graduate school, while an elective can be made a part of an undergraduate course in the same sense that agriculture, domestic science, or art is part of the high school course.

The value of practical experience in elective work can be measured solely by the methods of administration, including the supervision accorded. It would be but another form of exploitation of the student nurse, were she allowed to give any degree of service that would not have an educational value. Practical elective work, whether in the hospital or outside of it, or with an affiliating institution or organization, should be considered as part of the course and as such should be given its proper weight of credit.

I believe we should approach the matter of practical elective work very cautiously and should not encourage it outside the hospital until proper provision can be made to place the student under constant supervision. It will necessarily cause an added expense to the training school, as it deprives the school of the services of the student and necessitates replacing her in the staff of nurses. There is also the question of the student's car fare and possibly her lunch. It should be an added expense to an outside organization rather than the benefit of another worker, for it takes the time of the supervising or clinic nurse to instruct the student; and it is an expense to the student herself, for it requires her to provide suitable uniforms.

Actual experience in elective work may be obtained either in the hospital with which the school is connected, in an affiliated hospital, or in the community itself. In the hospital the familiar forms which we have known are head nurse duty, or assistant's work, or special operating room work. These may not have been considered as elective courses, but even as nonelective have contributed to the value of the training from the standpoint of added experience for the student.

*Read before the joint meeting of the National Associations of Nurses, Philadelphia, 1917; presented here by courtesy of the *American Journal of Nursing*.

Practical experience in an affiliated hospital is also not new and has been practiced in progressive schools for at least two decades and made compulsory by state boards of nurse examiners in order to supplement actual deficiencies in the home school. Elective work in affiliating hospitals is a different proposition, and means a voluntary agreement on the part of the home school to relinquish the student for a specified time, we will say, from four to six months, and solely for the benefit of the student, as, for example, where the student from a general hospital is sent to a state hospital for the insane for the purpose of experience in mental nursing. In these cases the degree and range of instruction and practice should be definitely specified and credit given.

In the various branches of public health work, which may include social service in the hospital, the same precaution will necessarily have to be carried out, otherwise, again, the nurse may become the victim of exploitation. The detail of the method of carrying out successfully a practical elective course in public health work or community nursing will of necessity have to be adapted to the given community. Cooperation with organizations seems to be at present the most feasible means of accomplishing this. The value of the work from an educational point of view will depend entirely on the standing of the organization concerned. This should come under the sanction and surveillance of boards of examiners, and, where there is an inspector of training schools, it should be part of her duty to make routine inspection where affiliating work is carried on.

A form of administration for carrying on practical elective work in public health nursing may be possible in communities where a group of hospitals are located, and by cooperation of these hospitals an instructor may be engaged who would take charge of the course and supervise the practical work. I believe it is not possible, in a necessarily limited undergraduate course, for a student to take any definite responsibility of patients or clinics; she can be considered merely as an observer or assistant. In small communities, supervision may more easily be given from the training school.

The question of electives may not properly belong here, only in that it may bring nearer the solution of the problem as to how the individual graduate nurse shall be prepared to meet increasing demands and how to utilize practically in the community the knowledge she has gained in her hospital.

Concerning graduate study, our imagination naturally turns to the courses now offered in our various centers which are contributing very materially to enabling the graduate nurse to meet the demands placed upon her. Many nurses are able to take advantage of these opportunities, but a larger number by far are not within reach of these centers, or may not be able, for various reasons, to take advantage of this study. But there are other means. Large or small groups of nurses, either in large centers or in our small towns or even rural sections, may organize for a course of instruction in sociology, civics, history, and development of nursing and other subjects allied to their work. Nurses should enter into meetings and gatherings where they come in contact with the live issues of the day and the social and political spirit of the community. Too long have nurses felt themselves so entirely absorbed in their work that it placed them apart from others; too long have they held back from mingling with other workers and taking their part in civic affairs. The training school may assume the blame for this, if we can credit the evidence of young graduates who have no knowledge of the

most intimate municipal, state, or national conditions bearing directly on their professional work.

Graduate study, to be of any value and give results, should be organized and properly directed until we can be thoroughly imbued with the thought that only by the eternal working over and renewing of the knowledge we already possess shall we be able to keep pace with social and economic changes and maintain our place in the social group. A sympathetic understanding of people and their needs can only be obtained by studying people; consequently, post-graduate study should be along the lines of sociology, political economy, and general community problems.

Opportunities for this are not lacking in any part of our country. There are the university and university extension courses and the university summer sessions; there are the high schools, the civic clubs, and the teachers' institutes. Again, there is literature in abundance if one knows how to find it and how to use it; the current periodicals and the daily press serve an inexhaustible purpose in keeping us informed as to public sentiment on civic and national questions in which the work of the nurse is often very intimately involved.

You may agree with me that the most important step in educational administration that will fit us to meet the situation as it exists today is that we should have, first, a standardization of entrance requirements of schools of nursing in the United States; second, a reorganization of the curriculum; third, opportunity for the pupil to exercise selection in the latter part of the third year; fourth, the continued encouragement of graduate study both within post-graduate institutions and by means of extension courses. In addition, there should be a greater development of educational and professional patriotism on the part of schools of nursing in their attitude toward the student nurse and to the objects of her studentship. Professional patriotism is establishing the point of view or the regard of the student for the integrity of her profession and her personal sense of responsibility for her course in the school.

There may be raised in this discussion a far-reaching problem to which I have given no attention, namely, the attitude of the people of the community toward the training school within its confines. The public is making its demands upon the graduate nurse, but is the public concerning itself with the preparation of the nurse in order that she may be able to answer its needs? It is very evident that the interests of the community will be better served when there exists a cordial understanding between the people and the school of nursing and when this school shall bear a definite relation to the general school system in the community.

As for the problems of legislation, here, again, are problems which parallel those of other educators, for who of us, listening to debates in legislative rooms on general education bills, have not been impressed with the similarity of our own position in these questions? Standards of education in no matter what line must be clear-cut and decisive before we can impress a legislative body of the need of protective or enforcing measures. Therefore the necessity that we should understand ourselves perfectly and bring to this understanding the combined wisdom of all of our activities.

We have obtained our first trench in legislative work, and now we must follow it up as well as guard it. We have established laws in forty-five states, which is but a beginning. Our next step is very apparent, that of stating in definite form what shall constitute a minimum standard

of education in all schools of nursing in the United States and placing upon this standard the stamp of our approval as a national organization. Legislation would undoubtedly be made far easier for a legislative committee were it reinforced by such a standard requirement.

Suitable legislation pertaining to nursing education is imperative, but suitable legislation pertaining to graduate nurses' work and to the work of attendants is likewise important and one in which we should now find ourselves actively concerned. I speak of tuberculosis, child welfare, and especially of school inspection legislation. Now that we have gone so far, we cannot afford to ignore all acts of legislators with which our work as nurses is so intimately associated. We must unite in our organizations to see that the utmost vigilance is obtained and be ready for the call to arms when adverse measures concerning public health welfare are threatening.

Suitable legislation for preliminary entrance requirements to schools of nursing is necessary to enable us properly to prepare the future graduate in our schools to meet the demand that is placed upon her by the public.

How One of the Smaller Hospitals Hopes to Help Meet the Need for More Nurses

BY MARY M. RIDDLE, Newton Hospital, Newton Center, Mass.

In addition to the many other problems confronting the American people and awaiting their solution is that of the depletion in the ranks of nurses, caused by war conditions and the necessity for a secondary army—an army of nurses to care for the sick and maimed on the battlefield.

The question has been discussed in all its bearings, but, however much is said and however long the debate, the truly thoughtful and unselfish always return to the same point in the argument, viz., that skilled nurses are needed as never before. They will continue to be needed in increasing numbers, and their number is now greatly depleted.

The appeal made by the Council of National Defense to the young womanhood of the country to study nursing expresses it thus:

"The situation is a grave one. We must provide the best nursing care for our army; we must carry on with undiminished energy the nursing work in our hospitals at home; we must also be ready as the war proceeds to care for great numbers of disabled men; we must increasingly safeguard health work in which nurses are engaged, especially where the health of the nation's children is at stake.

"Highly skilled nurses will be needed as never before, and in greatly increased numbers. In one way only can the loss of trained nurses be made good, and that is by training others to take their places. The others must come from the ranks of America's young womanhood, and they must come in great numbers if they are to meet the situation as it appears in all its alarming phases."

Trustees of civil hospitals, large and small, have sat in council upon this subject and have decided, most of them, upon their lines of action according to their ability and resources.

The Newton Hospital, in Newton, Mass., which is known as one of the smaller hospitals, or at least as a secondary one, having 165 beds, with a daily average of something more than one hundred patients, has felt the strain and responsibility caused by the conditions and has made some efforts toward relieving them.

Its trustees have made arrangements with the naval authorities whereby it has agreed to care for soldier sailors as needed.

The board of health of the city of Newton has placed a building at the disposal of the hospital authorities, to which fifty patients can be admitted immediately, and the

equipment for the building is stored in its basement ready to be set up for use at a moment's notice. Another fifty patients can be cared for in other parts of the hospital without particularly disturbing the present routine of work or without displacing any of the patients resident in the community who would naturally expect the care of the hospital.

It was a comparatively easy matter to secure space and hospital facilities for additional patients, but to provide nursing care seemed more complex, especially in the face of the fact that graduate nurses are scarce and opportunities for housing more pupils upon the hospital premises do not exist.

Accordingly, after due deliberation and a recommendation from the training school committee, it was decided to open a house where a new class may be provided for and where the preliminary instruction may be given.

The new home has been called the annex and will nicely care for fourteen students who are to be admitted there during the week of August 12. It is, by train and a short walk at either end, about ten minutes distant from the hospital. In good weather the students may find it possible to walk the entire distance. The house is fitted with well-equipped class rooms and work rooms for both theoretical and practical instruction. The home conditions are not only comfortable, but they are refining, and it is believed will promote the happiness of the residents.

In order that the instruction in domestic science may be applied, it is intended that the class shall provide for themselves. Groups will be appointed for the various departments of the domestic work, each individual will have an opportunity to serve in each and every capacity. They will have their laundry work done at the hospital, which will also bake their bread. Otherwise they will provide for themselves. There will be no servants in the house other than the occasional day worker.

Instructors will go from the hospital for certain class work, and other teachers will come from the outside.

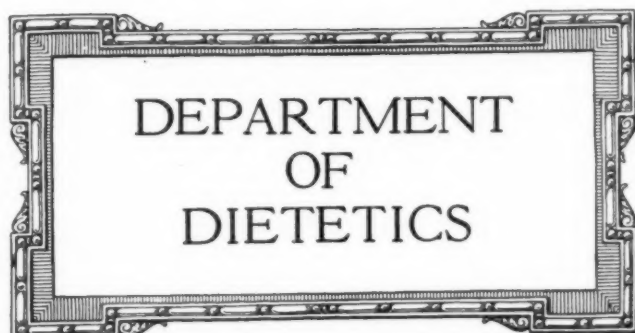
It is intended to make this preliminary course very complete and thorough, though it is the same as that outlined in the school's prospectus. The members of the class will have no hospital practice for some weeks; they will begin by having a few hours per day and will be admitted to the hospital at the end of the preliminary or probationary period.

The class is selected from a list of regular applicants, and they all enter for the full three years' course. When this class becomes an integral part of the training school another will be admitted and put through the same process.

If it should transpire that the hospital needs of the next six months do not call for the additional number of nurses, affiliations with some of the large hospitals in the city will be obtained to insure their thorough training. In no sense will the standards of instruction and practice be lowered.

The house will be supervised by Miss Ellen C. Yancey, who will also be an instructor. She will have an assistant appointed by the hospital. Miss Yancey is a graduate of the Boston City Hospital Training School for Nurses and has had much experience in hospital and training school work. The Newton Hospital is fortunate in being able to secure her services.

The actual expense of this undertaking is not yet known, but it should be kept at the minimum if possible, for in no case would the Newton Hospital wish to set an example of extravagant expenditure, though it does sincerely hope to bear its share of the responsibility in meeting the present and future needs of its sick countrymen, whether at home or in a foreign field.



Conducted by MISS LULU GRAVES,
Dietitian of Lakeside Hospital, Cleveland, Ohio.

Please address items of news and inquiries regarding Department of Dietetics to the editor of this department, Lakeside Hospital, Cleveland, O.

Food in all its phases has become one of the leading topics for discussion this year. An extensive and intensive campaign is being carried on to educate those who are planning and providing for food that they may know the needs of our body and the value of food materials, and may make practical application of this knowledge. Even the one who has merely paid someone else to provide his daily fare is learning that it is not the simple process which he had fondly imagined it to be.

Information pertaining to food constituents, their value or their harmfulness under given conditions, has been available for many years, but little effort has been made to acquire this information, and we as a nation have continued the extravagant waste as well as injudicious consuming of food. More interest has been shown and more real education has been given the general public along this line during the past year than in any five years previous to this.

Domestic science, dietetics, and allied subjects are at last receiving proper recognition; now as never before is the dietitian being given her just dues. This may mean she is receiving creditable acknowledgment, or otherwise, according to her ability to meet the present situation—labor difficulties as well as food.

The department at Washington and the various state departments are furnishing bulletins and other pamphlets which are most helpful to the housewife. These are put out primarily for the housewife, though they may be adapted to use in the hospital. The information given is authentic and the pamphlets are written in a simple, concise language that is easily followed. These treat of everything from planting the seed to the serving of the cooked product.

Such emphasis was given by newspapers and other publications all over the country to the need for planting gardens that thousands of gardens were planted this year by people who never planted anything before. These will furnish a great deal of food for family use in addition to the regular supply which the truck gardener and regular producer furnishes. With the responsibility of supplying food to her European allies resting on America, every bit of food which can be produced will be needed. Extravagance or waste of anything which may be used for food is not only a personal loss, but a national loss as well. Waste in the kitchen is but a small percent of the total when we consider the loss in transportation of perishable foods, the loss in storage of foods kept until they deteriorate or spoil, and the loss of foods allowed to spoil in gardens because the supply is greater than the demand of that particular family. The producer is not allowed to forget for an instant that he is a most important factor in the

the economic world today. He replies by asking what does it profit him to produce a large crop and have no market for it, or have it spoiled before it reaches the market. One remedy for this is preservation of food. Food may be preserved by canning, drying, preserving in a heavy syrup as jams or jelly, pickling, and refrigeration.

Refrigeration is a commercial process which we will not discuss. The other processes are merely different methods of arresting the growth or development of micro-organisms which cause food to spoil.

Canning is by far the most generally used process for preservation of food, and with the methods now in use it is as simple a process as any. The National Emergency Food Garden Commission at Washington has issued a pamphlet which gives very explicit information about canning and the various methods used. In a paragraph referring to canning as food thrift is found the following:

"It enables the individual household to take advantage of the summer's low prices for vegetables and fruits. It effects the saving of a surplus of foodstuffs that would otherwise be wasted through excess of supply over immediate consumption. It eliminates the cold-storage cost that must be added to the prices of commodities bought during the winter. Of vital importance, also, is that it relieves the strain on the transportation facilities of the country. This phase is especially emphasized for this year by the existing traffic situation. The railroads are already overcrowded with freights. With the advent of winter there will doubtless be congestion more serious even than that of last year. All this increases the need for home canning and proves that this is a national obligation."

The same obligation rests upon hospitals as upon the household in this matter, though there are hospitals where this work is impossible, especially at this time when labor is a great problem. In state, county, municipal, or other charity institutions where patient help is available, this difficulty is overcome. When the institution has a farm in connection, it would be most deplorable not to can the fruit and vegetables as they were brought in fresh from the fields and gardens. There is always a much greater quantity of these things ripening on the large county and state farms than can be utilized for immediate consumption. Not only is this a point in food conservation, but it also furnishes to the patients and employees a greater variety and better quality of food during the winter than could be bought with the apportionment usually made for this purpose. A comparatively small amount of equipment is required, and the work may be lessened if a part of it be done each day, or even small portions canned as they are left from the day's needs. It is the more imperative that this be done in every household and hospital where it can possibly be done, because there are so many of both households and hospitals where it cannot be done.

The only source of supply of a large number of our private hospitals is the market. Even with them there is great opportunity from time to time for buying some food which floods the market on that particular day. The vegetable or fruit available is generally sold for a very reasonable price and though it may be something too ripe for canning, it may be utilized in pickles or jams; this is apt to be true of berries, peaches, and grapes. No one who has ever lived in a hospital needs to be told how much the home-canned goods are appreciated, or how much home-made pickles, jellies, and jams are enjoyed.

Drying is an older method of food preservation and has two important points in its favor; first, economy of jars and economy of space, as the bulk is much less after the evaporation of water and the dried food may be packed so compactly that small space is required in comparison to that required for canned goods; second, the process is so

simple and the transportation costs so much less that the product can be sold at a price within the reach of nearly everyone. The flavor is most desirable provided the soaking and cooking are properly done. Practically all fruits and vegetables may be dried, and in nearly every home the necessary equipment may be had with slight trouble or cost. It may be done in the sun or in the oven. Quantities large enough for use in an institution are a little more difficult to obtain than in a home.

Pickling is a very satisfactory method of preserving some vegetables and fruits, but it costs more in proportion to results obtained than the other methods mentioned owing to the high price of spices and sugars. The pickled foods are a most welcome addition to the diet of well people, but are not desirable for the sick. It is necessary that the pickles be continuously immersed, as they mold or dry quickly; they should be stirred from time to time, as both brine and sweet vinegar have a tendency to settle to the bottom, leaving a weakened liquid at the top in which the pickles may become soft, or spoil.

No attempt is made to give directions or recipes here, as so much literature of this kind is available. Besides the numerous bulletins put out by the state experiment stations and the agricultural department at Washington, the National Emergency Food Garden Commission, 210-220 Maryland Building, Washington, D. C., will send a "Home Canning Manual for Vegetables and Fruits" and a "Home Drying Manual for Vegetables and Fruits" upon the receipt of two cents for postage. These manuals give explicit directions for equipment, as well as the process, and are well worth having.

In many hospitals it is almost impossible this year to get sufficient help to do the necessary things from day to day; these institutions cannot avail themselves of the advantages of preserving food for future use. The prospect is a trifle darker for them than for those in which provision may be made now for the winter needs. This fact furnishes one more reason why all who can do so should preserve their own foods, thus leaving a market supply for those who cannot.

The *Outlook* in June set this standard for us:

"Production at its highest point, transportation and marketing efficient, no waste in the household, and not an empty can or jar in the country—this should be the national ideal. We may not realize it in every respect; indeed, we shall probably fall short of this ambition, but if we faithfully do our best, we need have no fear of the future."

The trustees of the University of Chicago have established a Science Series in which they are publishing the latest results in scientific research. The sixth in the series is a small book on "Food Poisoning" by Edwin Oakes Jordan, chairman of the department of hygiene and bacteriology at the University of Chicago.

In the first chapter Dr. Jordan discusses the extent of food poisoning and the number of conditions from appendicitis to the cases of "simple abdominal distention resulting from gorging," which are conveniently diagnosed as ptomaine poisoning; the various kinds of food poisoning; and articles of food most commonly connected with food poisoning. What he tells us in this chapter is of great interest and of value to the most scientific medical man, though written in such simple language as to be of equal interest to the layman with no knowledge of science.

Other chapters on "Poisonous Plants and Animals," "Mineral Poisons Added to Food," and "Food-Borne Pathogenic Bacteria" point out the great need for caution in use of materials for food in which these might be present.

Both aspects of the use of food preservatives are given, and much emphasis placed in the need of further experiment and investigation on this subject.

Conservation of Food

BY DR. J. A. WESENER and GEORGE L. TELLER, of The Columbus Laboratories, Chicago.

[Continued from the August issue.]

In the conservation of food there are several factors which must be borne in mind. In the first place, there is no use lengthening out the food products for human consumption, unless by so doing the digestive factors and availability of the added material are fully taken into account. If by such lengthening processes you introduce certain elements which are not available as food to the human body, these, then, are not only lost from a food standpoint in other channels, but they may act as disturbing factors in withdrawing the available energy which is present. What we mean by this is that, while chemistry will show the number of heat units obtained from a definite quantity of material, the condition under which it is prepared for human consumption may change these factors very materially. While coal and fiber, when burned in a bomb calorimeter, will show heat units, they would have no value from an energizing standpoint when introduced into the human body. That is, the human body is not capable of converting these into energy.

We have heard much in the past, and especially in the present, of the wonderful nutritive value that exists in whole wheat and graham bread. From a purely chemical point of view, based upon the proximate principles present, the food value is practically the same as in white bread, but when these products are actually subjected to digestive tests, in vitro, the energy or digestive coefficient is considerably lower for these breads than for bread made from pure, refined flour. The analyses of home-made bread and graham bread, while being very similar as to the three important groups, namely, protein, carbohydrates, and fat, differ quite materially in the amount of crude fiber and natural mineral salts. Home-made bread runs about 9 percent in protein, 2 percent in fat, 56.75 percent carbohydrates, 0.25 percent crude fiber, and 1.05 percent mineral salts. Graham bread runs about 9 percent in protein, 1.8 percent fat, 51.4 percent carbohydrates, 2 percent fiber, and 2 percent mineral salts. Of the carbohydrates present in the graham and whole-wheat bread, a considerable proportion is of a nature which is not at all utilizable by the human body, as it belongs to the pentosan group, which is not digestible and yields no fermentable carbohydrates. It will be noticed that, while the protein and fat are practically the same in the whole-wheat, the graham, and the white bread, there is a material difference in the percentages of crude fiber and mineral salts, the crude fiber in the graham being practically ten times higher than in white bread, and the mineral constituents, independent of the added table salts, practically four times as high.

The mineral salts in graham and whole-wheat products are of much importance in the feeding of man, and this is especially true of the growing young. The bases, calcium and magnesium, and the phosphoric acid, which is present in the form of phytic acid, as well as a small amount of iron, are more abundant in the whole-wheat and graham product than in the white bread. On the other hand, the fiber, outside of its purely peristaltic action on the bowel, is a detriment from a purely food value standpoint.

[To be continued.]

PREVENTION OF BLINDNESS MATERNITY

Conducted by CAROLYN CONANT VAN BLARCOM, R. N.,
*Secretary of the Illinois Society for the Prevention of Blindness;
Chairman of Committee on Social Hygiene of the
American Nurses' Association.*

Please address items of news and inquiries regarding Prevention of Blindness—Maternity to the editor of this department, 30 North Michigan Boulevard, Chicago.

Possibilities of Social Service Work in an Eye Hospital or Dispensary*

BY CATHERINE BRANNICK, M. D., Chicago.

Hospital social service work, so-called, is now so universally recognized that there is no longer need of advancing reasons for its being. There is still, however, much difference of opinion as to the methods of introducing and conducting it. If the various aspects of the hospital's function are kept in mind and social service recognized as an integral part of the hospital machinery, methods take care of themselves.

Every hospital which undertakes the care of the sick poor has a fourfold duty—to care for the patient, to educate the physicians and nurses, to advance medical science by research and related work, and to give to the community an adequate report of its work and findings.

It is not sufficient for the hospital to offer its bare service to the poor and let them take advantage of it in their divers unenlightened ways. This is not the way in which the doctor treats his patients in his office. There he makes inquiry into the cause of the disease beyond the mere physical examination, and modifies his advice and prescription to suit the patients' intelligence and circumstances. This, of course, is impossible in the hospital, where he must see many patients in a limited time, and so the need of the social worker, or whatever she may be called, to do whatever follow-up work is necessary to insure that the patient actually gets what he sought from the hospital and what the hospital seeks to give.

In the education of the physicians and nurses as carried on in the hospital, the social basis of disease can be included only if the social aspects have been considered both in the history of the individual case and in the larger public health aspect.

In many forms of research work, as in the intensive study of certain groups, in occupational diseases and the like, investigation and follow-up work, as done by the social worker, are absolutely essential.

Hospital reports should be addressed to the public, not to the hospital's particular board of directors and its medical staff only. A hospital is essentially the laboratory of the community it serves, using the word "laboratory" in its broadest sense, and its findings should be of interest to the various community administratives, as of boards of health, industrial accident boards, etc.

The term "social service department" seems a paradox

*As the first social service eye work in this country was started at the Massachusetts Charitable Eye and Ear Infirmary by Dr. Brannick, her article on this subject has peculiar value.—Ed.

when used in connection with a hospital, as the work of a hospital, as such, is surely social service. It is only that, until the particular activity designated as social service work was introduced, the hospital was unable to carry out fully the objects for which it was founded.

From the point of view of expense, the organization of a large general hospital to include this social efficiency, as well as efficiency on the more purely medical side, may seem impracticable. The truth is, however, that the comparatively high cost of such service to date is due largely to the fact that all the work has had to be delegated to specially trained workers from outside the hospital. As medical sociology grows, much of this work will be incorporated in that of the doctors, the nurses, and the various hospital executives.

In the smaller special hospital or dispensary, whether it exists as a separate institution or as a department of a general hospital, this organization for a truly all-round efficiency is comparatively simple and the cost not at all formidable. Take, for example, the hospital or dispensary which treats diseases of the eye only. There is perhaps no better opportunity to do truly preventive work in medicine than in such a hospital, when the purely medical work is supplemented by what we call social service.

Beginning at the registration desk, since there is no question as to the department to which the patient should go, a socially trained person may admit and at the same time make a minimum social survey of the patient. The registration desk is of real importance in the smooth running of any hospital or dispensary, as here may originate many of the "grouches" which patients carry with them through the clinic, or into the ward, or even out into the community.

Within the hospital there are a surprising number of groups in which some form of social service seems necessary.

Taking first the various groups of children, one of the largest and most important is that of the children with phlyctenular keratitis accompanying a general poor physical condition, the result of faulty hygiene. Treated merely locally, this condition may, and usually does, recur again and again, until the vision is permanently affected. For the rational treatment, directed at the underlying cause, some degree of follow-up work is essential for the majority of patients applying at a dispensary, to insure general treatment when necessary and to give specific instructions in the home. Where hygiene is lacking, as it is in these cases, its principles can best be taught in the place where they are to be applied.

Although there is very little actual blindness as the result of this disease, yet there are scars of the cornea which may be very trying later in life, by limiting the vocational possibilities for the individual. Preventive work with this group is therefore more important than the severity of the symptoms in themselves suggests.

Another form of keratitis occurring in children in which the doctor's effort must be supplemented, in order to get the results at which he aims, is the interstitial variety. Here it is difficult to see how effective work can be done without some system of follow-up. These children must be kept under general treatment for discouragingly long periods, and school work, unless specially adapted to their needs, must be interrupted for many months or even years. Under the best possible treatment, medical and social, they are still sadly handicapped, but, under the hit-or-miss attendance of these patients at the ordinary dispensary, they are indeed a pitiful group.

Treatment of children with congenital cataract can be

made much more effective by adequate follow-up work. The long period during which these cases have to be under observation gives a good opportunity for failure or delay in return, a delay which may very seriously influence the child's normal development and education.

In the ordinary eye dispensary, the largest group of patients, consisting of those who need refraction only, is regarded as the least important, both by the hospital and apparently by the patients themselves. It is to be expected, then, that in this department the dispensary may be least efficient, in the sense that much difficult and trying work on the part of the doctors is wasted, because of the large number of patients who, for one reason or another, fail to get the glasses prescribed. The close relation between general medicine and ophthalmology holds true, not only in inflammatory conditions of the eye, but also in the many manifestations of eyestrain, though the relation of cause and effect may alternate in the two conditions, and many of these cases are among the most important treated at the dispensary.

If one considers in this group only the schoolchildren, the need of some follow-up system is apparent. A refractive error in a schoolchild, uncorrected, may result in various feelings of bodily discomfort—headache, nervousness, a general irritability—which quite apart from the defective vision itself, interfere with the acquirement of knowledge in its full significance. The knowledge acquired in school, in the ordinary meaning of the term, is of much less importance than the habits formed and the attitude toward life. Habits of inattention, of bad methods of work, acquired in school, are carried into the working life of the individual, and a child's whole attitude toward life may be modified by a habit of discouragement and failure in school.

Going a step further, the dispensary which has the child's record and understands his limitations in the matter of vision is in the best position to advise the school along vocational lines.

On the more purely medical side, follow-up work in these cases as a preventive measure, is important. This is especially true of conditions tending to be progressive, as in myopia, in which progression is often prevented if the error is corrected early and the child made to wear the glasses constantly.

The disease in which treatment by follow-up work is most distinctly a preventive measure is ophthalmia neonatorum. This has been demonstrated in many states through the working of the law which makes this a reportable disease. The follow-up work here, in its limited sense of looking after the individual patient, is especially important in the eye dispensary where treatment is given through the out-patient department. The proper method of treatment in the majority of these cases is, of course, in the hospital ward, but there are nevertheless many cases which could best be treated in the out-patient department if there were some system of insuring return of the patient and of giving instructions in the home when needed. The mere difficulty in the matter of feeding these infants in itself makes this form of treatment desirable whenever possible.

The follow-up work with this group is most important, in its larger educational aspect, in reporting to the proper public health agencies and to the community the result of the investigation of the medical and social aspects of individual cases. The work already accomplished in many states by a systematic campaign of education on this subject shows some remarkable results. In Massachusetts, where the work for prevention of this particular form of

blindness has been especially active, the state commission for the blind reports that the admissions to the schools for the blind in the state show a marked decrease in the number of blind from this cause in the past few years, a decrease from 50 percent to 17 percent in the total admissions.

In the states in which this has been made one of the reportable diseases, the enforcement of the law has furnished a nucleus for educational work, but even here the eye hospital or dispensary is in the best position to give the facts which the community should know. In the states which as yet have no law touching this disease, the hospital has an opportunity, and even a duty, to initiate the campaign against blindness from this most preventable cause.

Any work for prevention must of necessity be largely a matter of education. Perhaps the best example of preventive medicine to date, in the department of ophthalmology, is the work of the United States Public Health Service in handling the cases of trachoma in the rural districts of Kentucky. The methods of the service have included an extensive follow-up system accompanied by other means of popular education, and the results show the efficiency of these methods.

Among the adult patients, one of the most important groups, from the point of view of preventive medicine, is that included in the cases of industrial accidents and occupational diseases, the result of systemic poisoning or merely excessive eyestrain. As individuals, the members of this group need more than purely medical attention to conserve the remaining sight—they need help in choosing the right occupation for the future. As a group, they are especially important in the larger aspect of prevention, in that they can be used to point the moral of prophylaxis of eyestrain and injury, and to bring about protective legislation.

One might continue indefinitely grouping the patients according to the eye disease, and would probably find in each group some need of supplementing the purely medical work, though the need is obviously greater in some groups than in others. In addition, follow-up work will be indicated in many cases, not because of the nature of the disease, but because of the nature of the patient or the purely social aspect of the case.

It may appear that a follow-up system, to cover these various groups and individual cases, would have to be an elaborate one. In practice, however, much of the work may be done through hospital routine, in improved methods of history-taking and record-keeping, and much of the actual work of follow-up can and should be done through public health and other medical social agencies in cooperation with the dispensary. Here, however, there is a tendency in practice to ask cooperating agencies to do work that really belongs to and can better be done by the hospital, and it too frequently happens that the patient comes to the ground in the midst of overmuch cooperation. The importance of this is not limited to the work for the individual patient, but is equally important in the educational aspect of medical-social work, as conclusions, medical or social, should be drawn only from case work that is well done.

Prevention of Blindness in Pennsylvania

The board of directors of the Pennsylvania Association for the Blind have voted to employ one nurse who shall devote all her time to saving sight. A member of the board has agreed to provide the salary and expenses of the nurse for a year in order that the venture may have a fair trial.



FOLLOWING A VISION OF BETTER MEN AND WOMEN

How Montgomery Ward & Co. Are Rapidly Expanding Those Departments Which Concern the Welfare of Their Employees

BY FRANCES KIRKWOOD, Educational Department, Montgomery Ward & Co.

"Welfare" in the three plants of Montgomery Ward & Co. means, primarily, all those special devices of the educational, medical, welfare and employment divisions, and their related divisions that have for their only purpose the self-improvement of the employee. The greatest service of these divisions is that they are penetrating currents of association between all the departments in the house. It isn't possible to detach any special achievement and say: "This is the work of the welfare department." The welfare department would be the first to resent any such singular isolation. Every operating superintendent in the establishment is a welfare head, for his department, by virtue of his responsibility for the people in his care; and the special welfare departments are agents for the better service and the more direct response of those employees. If he is capable of any sustained perspicacity—and he must be if he keeps his job—he soon learns the effectuality of consulting with these departments in cases which he cannot adjust alone. He learns that the anemic girl works better if under the physician's guidance; that the morally indifferent girl is a case for the welfare head's kindly assistance; that the ambitious youth finds stimulus to better things from the work and ideals of the evening classes. He learns the absolutely direct relationship between his labor output and the health and moral outlook of his employees. He learns that his vigilance works two ways, for keeping his men and women fit means infinitely more to themselves than to anyone else, even though his object is, first of all, better service for the firm.

The positive proof that executives of Montgomery Ward & Co. realize and utilize these—shall we call them "auxiliary" departments?—lies in the growth and expansion of the departments themselves. Keen-sighted business men are not interested in the systematic development of institutions whose purpose is mental anesthesia to employees and outsiders. Moreover, a department maintained for appearances is planted in a conspicuous corner with a bay-tree or a palm marking the entrance—and it doesn't grow.

The employees of Montgomery Ward & Co.'s various plants are truly large families. As you know, practically all mail-order shopping is done from the catalog, at home. Comparatively few customers come to the store and these do not enter the operating divisions except with attendant guides. Employees, not having the interruption

of outsiders, are very intimately associated; this results, not only in a greater interest in each other, but also in that same closeness of feeling for the establishment that you have for your home town, your school, your college. And doubtless the rather paternal care which executives give their people is a result of the same emotion that inspires the town fathers or college professors.

These welfare departments—we speak of them collectively for convenience—are the direct expression of the constructive spirit that is obvious in all the Montgomery Ward & Co. houses. It speaks in the watchful care of sanitary kitchens and restaurants located on the bright, cool top floors, where variety in menu is achieved at a very nominal cost for thousands daily; it speaks in libraries, recreation rooms, tennis courts, baseball fields; in weekly inspections of working conditions; in corps of men and women employed in constantly improving those conditions; in countless little things such as the lending of umbrellas in case of sudden rain, dry clothing for those who are caught unprotected by the rain en route to work—their own clothing being dried for them in the engine rooms—in drinking fountains supplying distilled and cooled water; in ventilating and sanitary devices. These are but a few of the indispensable steps in the striving of Montgomery Ward & Co. for the highest human efficiency.

These are generalities—and you want special information. In the following paragraphs we are writing about the Chicago house of Montgomery Ward & Co.; any statistics given are for the Chicago house alone, but the methods employed are the same in the three plants.

There is no welfare feature more important than that which cares for the health of the employee. The medical department in the Chicago house was established in 1902 with one physician and one nurse. At present there are three physicians—the consulting surgeon, who is staff head; two resident doctors, and four nurses, one of whom is a visiting nurse. Each plant is equipped with offices and a small emergency hospital.

Every applicant for employment is given a preliminary examination. If he is employed this is followed in three weeks by a more thorough physical test. All emergency cases are cared for in the plant hospital. Employees who have been with the firm one year or more are given attendance of doctors and nurses at their home, ambulance and hospital service if necessary. Hospital care is provided for operations and non-surgical illnesses requiring it. In the office of the Chicago plant in 1916, attention was given more than 20,000 cases; there were 186 hospital cases and 95 operations.

There are few serious accidents in a mail-order establishment, but in departments where girls are closely associated in clerical labor there is always danger from contagious disease. Of course, the most dreaded of these is tuberculosis. This was the original reason for instituting the serving of malted milk twice daily to anemic employees—at 10 a. m. and 3 p. m., when energy is at lowest ebb. A 12-ounce glass, double strength, is given, free. Its great cost to the company is more than offset by the results in health and energy.

The dental department is independent, but coordinate with the medical and welfare divisions. This department is presumably self-supporting. Advice for care of teeth and examinations are given free; further work is done at cost of materials used, on the company's time without loss of wage to the employee. "Campaign against the low-priced quacks" is the first slogan of the dental depart-

ment head. In the Chicago house there are five dentists and one assistant nurse.

If you have ever been tied down for any length of time to uncongenial work you will appreciate the vocational guidance departments of the Montgomery Ward & Co. houses. Through various psychological tests these departments successfully place men and women in work to which they are naturally adapted.

The office of the welfare department is centrally located, in close proximity to the medical and dental offices, the rest rooms, the silence-rest room, the library, and the recreation hall. If you should come to visit, come at noon; then will you see the welfare department at its happiest and best. An especial feature is the Friday noonday Fellowship Meeting for girls, where they all gather to sing, and listen to brief inspiring talks by well-known men and women from the world outside.

The welfare head spends a good part of each day in personal consultation with men and women who come to her for assistance or advice. Through her wide interest, she is able to influence tremendously the trend of the lives of these people. Under her direction the visiting housekeeper makes her daily calls, reports conditions, plans solutions of family problems. A doctor's care, a supply of groceries in time, a new apartment with air and sunshine—these are some of her daily tasks in conjunction with the visiting housekeeper. Within the house she keeps in touch with every department superintendent, consulting with him or her in cases that arise in their respective divisions.

The most delightful of all the welfare and educational features are the evening classes. These meet four nights weekly, after working hours, from five until eight. A lunch is first served in the restaurant; then follow classes in gymnasium, English, typewriting, comptometer, dictaphone, shorthand, spelling, arithmetic, mail-order correspondence, sewing and social dancing. Classes for men meet on Tuesdays and Fridays; those for women on Mondays and Thursdays. Records are kept and students promoted in their day work according to their merits as shown by these records. Not the least of the success of these classes is the spirit of fellowship, the close friendships, the inspiring zeal with which they are attended. The welfare head gives a fifteen-minute talk before the assembled students each class evening, and she feels that this is her finest opportunity for extensive personal touch with the girls in the company's employ.

A plan now under way in which the welfare department of Montgomery Ward & Co. feels great pride is a vacation plan for girls—a farm in some desirable locality, with cottage accommodations, tennis courts, bathing, hiking, canoeing, dancing—a glorious two weeks of out-of-doors in summer for every girl in the house, at a nominal cost of not more than \$12.50 for the entire trip.

Just now this department is active in the equipment and training of Red Cross first-aid classes for the girls and a sanitary training corps of men. Equipment is provided by the company, lectures given by the consulting surgeon, and students are privileged to attend his operations at the Hahnemann Hospital. The Red Cross auxiliary is made up of girls who volunteer their time after working hours for the making of hospital accessories, the company furnishing materials and instructors. The men's sanitary corps has over forty members; in case of extreme need, Montgomery Ward & Co. will be able to give an adequately trained, fully equipped corps to the U. S. service at a cost of between \$4,500 and \$5,000.

Does it pay? It certainly does. From the standpoint of the firm it is evidenced by the alacrity with which executives plan for it more and more extensively, through their assurance of its worth from successes already achieved. Of the employees' standpoint the firm can judge, of course, only from attitude, from the quality of response, from the reciprocating loyalty that makes itself felt in an all-pervasive atmosphere of interest and pleasure in their work.

And you just *know* it's right—that big ideal of Montgomery Ward & Co. that is back of it all for the instillation and fostering of more self-respect, more self-dependence, and the subsequent self-realization in every man and woman in the company's care.

* * * *

A RETIREMENT PLAN FOR SUPERANNUATED EMPLOYEES

Colorado Fuel and Iron Company Announces Plan for Retiring Old Employees on Pension

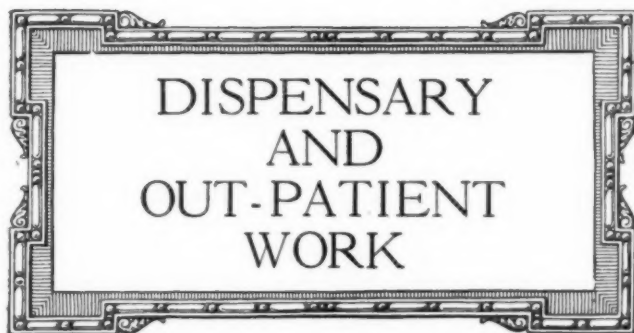
The board of directors of the Colorado Fuel and Iron Company has recently announced a plan for retiring employees who have grown old in its service. It has not been the policy of the company to dismiss employees on account of advancing years. The practice has been, on the contrary, to provide suitable employment or to make other special provision for those who had grown too old for their accustomed work. The new service retirement plan is an outgrowth and enlargement of that practice.

Compulsory retirement is provided (except in special cases, at the discretion of the retirement board and the board of directors) for all men employees of 65 and all women employees of 55 who have been twenty years or longer in the service. Men aged 60 and women aged 50, if they have been thirty years or longer in the service, may be retired at their own request or in the discretion of the board. The board also has discretion to retire on special allowance any employee who has been fifteen years or longer in the service and who is permanently incapacitated for any work, or any employee who has been at least twenty years in service if advancing age renders such retirement advisable.

The regular monthly allowance is to be 30 percent of the average pay per month of service during the ten years immediately preceding retirement. Thus a retired employee whose pay has averaged \$80 per month for the ten years before retirement will receive \$24 per month as a retiring allowance. No regular allowance, however, is to be less than \$20 a month. The amount and duration of all special allowances are to be determined by the board.

In the discretion of the board, payments may be continued for a limited period to widows and orphans. To insure that employees shall not lose the benefits granted them, no assignment of payments will be recognized or permitted; nor will allowances be liable, before payment, to claims of creditors or attachment for debt. The grants being purely voluntary, the board may withhold, suspend, or terminate them for misconduct, violation of law or of the rules of the board, or for other causes sufficient, in the judgment of the board, to warrant such action. The board may, if it thinks best, pay the allowance to some other member of the family.

In order that all employees hereafter engaged may have an opportunity to qualify for a grant by twenty years' service before the age of 65, the time for compulsory retirement, no new employees over 45 years of age will be employed.



Conducted by MICHAEL M. DAVIS, Jr.,
Director of the Boston Dispensary.

Please address items of news and inquiries regarding Dispensary and Out-Patient Work to the editor of this department, 25 Bennett street, Boston, Mass.

The Function of a Dispensary*

BY JOHN E. RANSOM, Superintendent of the Central Free Dispensary, Rush Medical College, Chicago, Ill.

From the point of view of community welfare work, the most evident function of a dispensary is to provide efficient medical service to people who are unable to pay for the services of private physicians and whose illnesses are of such nature that they can come to the dispensary from time to time for treatment. The dispensary differs from the hospital primarily in the fact that its patients usually do not need the constant attention, bedside care, institutional control, etc., which make hospital care necessary. Putting it another way, we may say that dispensary patients correspond to those who receive medical attention at the office of a physician rather than in the operating room, in bed at home, or in the hospital. Of course, this must not be taken to mean that the medical needs of the dispensary patient are not of serious import.

Most dispensaries are organized on the basis of special clinics or departments. This means that if a patient is suffering from a throat condition, he is examined and treated by a throat specialist; if he has eye trouble, he is seen by an oculist. If his illness is one difficult to diagnose, he is seen by several different specialists, and his treatment determined by what they find to be the nature and cause of his malady. The better dispensaries are so equipped that good diagnostic work can be done except in those cases in which observation in a hospital is necessary to arrive at a diagnosis. If it be found that a patient needs hospital care, the dispensary should be able to see that he gets it.

This form of medical organization, termed "group practice," is thought by many physicians to be the form which the practice of medicine is likely to take in the future. In fact, the far-famed Mayo Clinic at Rochester, Minn., is a great dispensary so far as organization is concerned. Thus, from the point of view of organization we may say that a dispensary is usually well equipped to perform its function so far as the medical treatment of sick people is concerned.

But the dispensary has other functions besides those bearing directly upon curative medicine. It can have a large part in the community's preventive medical program. To a dispensary come many patients who are in the incipient stage of their illness. A man, let us say, has laid off from work for a day because he is not feeling well. He comes to a dispensary and there finds that he is in the incipient stage of some disease which, if allowed to develop and become chronic, will eventually incapacitate

him for work. He may, by making certain changes in his mode of living, his work, etc., have adequate medical care and be restored to health. This may mean that he will have to quit work for a while, have preventive convalescent care, etc. On the other hand, he may go on with his work, continue to live under the conditions which have produced his illness, and eventually either live through a period of incapacity due to his disease, or die prematurely from it, or do both.

To give this man the preventive treatment he needs at the time his condition is first discovered will cost money. It may mean that a relief organization will have to put money into the support of a family whose wage-earner is not really very sick and who can work, and who probably would rather work than accept charity. It may mean that if we are to do what we ought to do for this man and hundreds of others like him, our facilities for preventive convalescent care will have to increase and develop greatly. But if this work is costly, what shall we say of the alternative course, which usually means waiting until nothing can be done before we attempt to do anything?

Education in personal, family, and community hygiene should have a larger part in the program of our dispensaries. Diabetics, cardiacs, consumptives, syphilitics, and gonorrheics need instruction not only in how to help cure themselves, but, also, in case of the last three types of patients, in how to avoid being a menace to the health of other people.

With the increased carefulness on the part of industry in the selection of employees, we are finding a growing group of rejected applicants for work, discarded because of some physical handicap which makes them less desirable workmen than were they physically sound. What some of these handicaps are may be seen from the following queries from a questionnaire which is being sent out to a large number of industries: "Do you accept applicants for work who have hernias, flat feet, varicose veins, who are blind in one eye, who have lost any part of an arm or leg, who have tuberculosis, organic heart disease, nephritis, high blood pressure, who show signs of syphilis?" Then comes the question: "What suggestions do you make to applicants who have any of the above handicaps whom you do not accept for employment?"

Some of these applicants who are rejected in one place find employment in another, depending on the type of physical impairment they present, on the condition of the labor market, and on the care or lack of it exercised by employers in the selection of employees. Others do not find work. We have seen in a comparatively short time several men who are breaking down morally because they cannot find work on account of some physical handicap. They were giving up the fight. They felt that the world was against them and that there was little use of trying. It will probably be only a question of time before some agency, charitable or correctional, will be trying to solve the complex problems some of these men will present. Some of the conditions which lead to rejection yield to medical or surgical treatment.

At the Central Free Dispensary in Chicago we are making a special study of rejected applicants for work. Several firms are referring to our evening clinic in Industrial Medicine and Surgery all of the applicants they reject on account of physical handicaps. We are studying these men and outlining remedial measures. For those who need hospital care we are arranging that. Some need only industrial adjustment or readjustment. It is our purpose to help this group obtain employment in which their handicap will be the least possible hindrance to efficiency.

*Extracts from paper read before the Chicago Council of Social Agencies.

In the field of social hygiene, the dispensary has important contributions to make. Especially is this true because syphilis and gonorrhea are usually amenable to ambulatory treatment. Our immediate problem with these diseases is that of cure and of rendering the patients non-infectious. Our work should not end here, however, but should include the education of patients in the protection of themselves, their associates, and their families, present and prospective, from the ravages of the so-called venereal diseases.

In the education of prospective mothers in proper prenatal procedure, in providing adequate care for many who are to be confined in their own homes, in emphasis on the value of infant life and on the superiority of modern scientific care of babies and children over the traditional methods so productive of infant mortality, dispensaries have another important function.

A dispensary may be a valuable institution in a community, not only because of what it is doing, but also because it can be utilized for still further service in promoting community welfare through conservation of health. In a sense it is a laboratory in which needs are discovered and analyzed. One of this community's needs, as demonstrated over and over again in our hospitals, dispensaries, and relief societies, is for greatly increased facilities for convalescent care.

In the first place, there are many patients discharged from our hospitals whose recovery will be retarded if not prevented because they cannot receive in their homes proper convalescent care, and because they cannot be relieved of household and other responsibilities which they are not yet strong enough to bear.

In the second place, we have great need for preventive convalescent treatment. There are coming to our dispensaries daily men and women who are breaking down in health because of the heavy loads they are carrying, the lack of proper food, unfavorable home conditions, and the like. Many of these need rest, fresh air, and good food rather than medicine. Some of them are just beginning invalidism, which, if unchecked, eventually renders them and their families dependent upon charity for their support. Our dispensaries can furnish to the community evidence of its great need in this direction. When the community has been sufficiently educated and spurred to action in providing the needed convalescent facilities, our dispensaries may well be utilized as receiving stations for our convalescent homes.

Such are some of the functions of a good dispensary.

Box Files

If an unkind word appears,
File the thing away.

If some novelty in jeers,
File the thing away.

If some clever little bit,
Of a sharp and pointed wit,
Carrying a sting with it—
File the thing away.

If some bit of gossip come,
File the thing away.
Scandalously spicy crumb,
File the thing away.

Do this for a little while,
Then go out and burn the file.

—John Kendrick Bangs.



ALBERT ALLEMANN, M. D., Foreign Literature.
Army Medical Museum and Library, Office of the Surgeon-General,
United States Army.

Hospital Organization. F. G. Murphy, M. D. Jour. Iowa State Med. Soc., 1917, VII, No. 6.

Dr. Murphy believes that in towns in which there are two or more physicians there should be mutual division of labor and that the spirit of the profession is now especially favorable for such division into groups. Each group, he believes, should have a recognized surgeon, internist, eye, ear, nose, and throat specialist, urologist and bacteriologist, who in some groups might also act as roentgenologist. As expert team-work is a comparatively new plan, there are few precedents to follow and each team probably will need to work out its own system. The internist is a very important member of the group, for the more expert he is the fewer the number of surgical operations necessary. It will not be necessary that every patient who consults one member of the group should be seen by every one of the team. The patient should be put to as little inconvenience as is consistent with thoroughness. The important consideration in group diagnosis is that it be thorough and relatively inexpensive to the patient, and that the services of every member of the staff be available when desirable.

A Prison Eye Clinic. Frederika Farley, R. N. Am. Jour. of Nursing, 1917, XVII, No. 8.

In April, 1916, the Mutual Welfare League of Sing Sing Prison appealed to the New York State Commission for the Blind for aid for a colored inmate, about to be discharged, who had completely lost his sight during his seven-year confinement. At the same time the commission was asked by relatives of another man, who was rapidly losing sight, to attempt to obtain for him a pardon from the governor, so that he might be sent to a hospital for treatment to save his sight.

These appeals resulted in the asking and granting of permission from the prison authorities to conduct an eye clinic in Sing Sing for the inmates. The clinic started in April. The junior member of the commission's board of ophthalmologists volunteered his services for this clinic, with the aid of the commission's social service nurse.

The prison hospital equipment was found to be excellent and only a few extra instruments were required for the special work. It was arranged that the nurse should see all new patients, take their histories, and, with the aid of an inmate who understood refraction, do the simple refractions each Friday. On this day she would also see all old cases that needed treatment and give it to them. Then on Mondays the doctor would see all these new cases and all old ones that had to return for further examination. The doctor is able to see and thoroughly examine eighteen or twenty men in the two hours he spends at the prison, and cases there can be followed to completion.

At the time Miss Farley's article was written, 135 patients had been examined; there had been seven operations, four patients were awaiting operation, and many had been referred to the nerve, nose and throat, ear, and dental clinics.

There has been a surprising lack of infectious eye conditions. With the exception of two infectious cases appearing in men newly admitted and immediately placed in quarantine, the cases were made up of acute iritis, chronic iritis, glaucoma, detached retina, optic atrophy, pterygium, hyperopia and presbyopia, myopia, and six injured eyes which required enucleation to preserve the sight in the uninjured eye.

Glasses are supplied by the state when the men cannot pay for them themselves. Through a friend of the prison it has been possible to supply first-class artificial eyes to all the men who have need of them.

The prison officials have in mind a very complete hospital department, and, as soon as all the acute cases are seen to, a routine examination is to be given to every man in the prison to check, if they exist, any hidden eye defects. The workers in the various clinics now organized are giving the commission generous cooperation.

The Hospitals of Kansas and the Kansas Hospital Association (President's Address). S. Murdock, Jr., M. D. Jour. of Kan. Med. Soc., XVII, No. 6.

Dr. Murdock says that small hospitals have been established in Kansas in the majority of counties. He has visited many of them during the past year. They are usually located in a resident property with a doctor's office, a room equipped for operating, and an x-ray room. The kitchen department is handled in the same manner as in the private home. A trained nurse with one or two understudies is in charge of the house. That is a description of the small hospitals which applies to the larger hospitals, except that the kitchen department in the larger institutions is handled on a larger scale and more in accordance with hotel methods. In small hospitals the absence of the pathological laboratory is conspicuous. In the larger hospitals there is usually a room set aside for pathological laboratory carefully locked up and not in use. Dr. Murdock expresses great respect for the men of the state operating small hospitals. They are, he says, doing splendid work and raising the standard of the profession. He recommends team-work where possible, with quarterly meetings of the staff and with unequivocal action against the practice of fee splitting. He emphasizes the necessity for the organization of hospitals in one association.

A Study of the Problem of the So-Called Defective Delinquent and What Has Been Done in Massachusetts. L. Vernon Briggs, M. D. Boston Med. and Surg. Jour., 1917, CLXXVI, No. 11.

The term "defective delinquent" is perhaps a legal rather than a medical term, though the intention in coining it was to bring together the two divergent points of view, the medical and the legal. It is intended to apply to a class that is not defined by the terms "mentally ill," "feeble-minded," or "criminal." Such persons are unsuitable subjects equally for state hospitals, for correctional institutions, and for life at large in the community. In the hospitals, they are incorrigible trouble-makers; in prisons, they prove apt pupils in crime and invariably return after parole or discharge; in the community, they recruit the ranks of the vicious, alcoholics, paupers, and prostitutes. Surveys of the population at the Bridgewater State Hospital and of the Massachusetts State Prison at Charles-

town brought out that a certain percentage of the inmates in each case came under the "defective delinquent" classification.

Dr. Briggs says that these defectives are to a great extent creatures of habit. One is always stealing, another setting fires, another sexually immoral. "A careful study of the individual would probably lead to the selection of an occupation or trade as an avenue which would take that person out of chaos into a useful and happy life." Dr. Briggs suggests a plan along the following lines:

This group should be segregated in a separate building or buildings, where the members may be individually studied medically and educationally. The institution should be under expert medical supervision, but should be called a school or training school rather than hospital or any name suggesting custodial treatment. The organization should include one or more psychological and vocational experts and social workers, and a pathologist. Well-equipped laboratories should be a part of the plan. Instruction should be given in the three R's, ethics, hygiene, manual trades, and domestic arts. A school of this kind, Dr. Briggs thinks, should be able to graduate into the community a number of its pupils each year, who should then be under the supervision of the social worker. Many will never graduate, but all should be given the opportunity to prepare themselves to go out into the world and make good.

After all is said and done, however, the trend of modern criminologic and psychiatric work is preventive rather than curative. Defective immigrants should be turned back at the port of entry. More important even than measures for the reclamation of defective delinquents would be careful yearly psychological examination in the schools, which would detect many defectives before they have become delinquent, thus permitting treatment or adjustment to a suitable environment.

Some Hospital Problems. Lawrence W. Littig, A. M., M. D., M. R. C. S. Jour. Am. Med. Assn., 1917, LXVIII, No. 13.

The hospital which places its wards and its operating rooms at the disposal of all alike, says Dr. Littig, is a menace to the community. He qualifies this statement by saying that his remarks apply to the open hospital as usually conducted in communities of from three thousand to one hundred thousand inhabitants, not to large city hospitals or to hospitals connected with medical schools. Most open hospitals either have no staff at all, or have a nominal staff which meets "once in ten years," or "when a row is on." The great characteristic of the usual open-hospital staff, in Dr. Littig's opinion, is an all-pervading inertia, the most effective barrier to progress. The evils of the open hospital, moreover, do not appear to be self-limited; there is no promise that they will be corrected from within. Publicity is the only sure corrective. Investigation and classification of hospitals promises splendid results.

"Closed hospitals," says Dr. Littig, may be undemocratic; they may not promise the best for either the profession at large or for the general public; but somewhere between them and the wide-open hospital there will be found a plan which will give every properly trained and right-minded man an opportunity to work out his destiny, and which will protect the community. The open hospital must be transformed into a restricted hospital, and by a method that is fair—such a one as this: When a properly trained but untried licensed practitioner asks to use the operating room, the answer will be: "Yes, but like every other man operating in this house, you will bulletin your

operation the evening before. The superintendent of the hospital and one or more staff members may be present. You are on trial, but so long as you have any privileges here, you will have all the privileges. You are welcome in the operating room when others operate, and at the weekly staff conferences. If your work is satisfactory, you may come again, and after a few years you may be elected to staff membership. But if your work is not satisfactory, why, we shall regretfully inform you that we have no unoccupied beds. This is not a closed hospital, but it is a restricted hospital."

Among the agents of publicity which will aid in the reform of hospitals are the American College of Surgeons, the requirement of the hospital fifth year, and the registration of nurses. Even the possibility of investigation by the American College of Surgeons has produced good results, Dr. Littig says. The requirement by medical schools and state examining boards of the hospital fifth year cannot fail to make its influence felt even more sharply. When this requirement comes into effect, it will be necessary for both medical schools and state boards to investigate hospitals seeking interns as to the character of the work done. Another opening which will enable state boards to investigate and largely control hospitals is the registration of nurses from the hospital training school. The board which examines and certifies young women for registration as nurses has the right to investigate the work done by the hospital where they were trained. The state board cannot classify hospitals, Dr. Littig remarks, because the friends of a discredited hospital would immediately rise in arms, would term the action of the board arbitrary and unfair, and would soon set in motion political machinery embarrassing to the board. But, if candidates for nurses' registration fail to meet requirements, the examining board may send them back for an additional three months' or six months' preparation, and neither the hospital itself nor its friends could protest without directing attention to the shortcomings of the training school.

Incidentally, Dr. Littig protests against the injustice with which a young woman is treated who realizes early in her course of training that she is not receiving satisfactory instruction. "Let her try to gain admission to some other school, even if willing to forfeit the time spent in training, and she will apply to many before attaining her object, if she succeeds at all." Dr. Littig quotes a hospital director (a physician) as saying that the American Hospital Association might well consider this matter.

Hospital Care in the Province of Pavia (L'assistenza ospitaliera nella Provincia di Pavia). Dr. L. Dori. Osp. maggiore, Milano, 1917, V, No. 1.

The province of Pavia with a population of 517,589 inhabitants has eighteen hospitals with 1,275 beds in all. Less than fifty physicians are employed in these eighteen hospitals. Only two-thirds of them are exclusively employed in the hospitals; the others have their private practice besides. In the hospital of Pavia there is one physician for every twelve patients; in the hospital of Stradella one physician attends to thirty-three patients. The average annual expense for each bed is 1,500 francs (about \$300). There are no special tuberculosis hospitals in the province. Tuberculous patients are placed in the general hospitals and only in three of the latter have special divisions for tuberculous patients been established. The author concludes by stating that while hospital care in the province of Pavia is entirely insufficient, it is superior to that in many other regions in Italy.

The New Building of Indherred Hospital in the Northern Trondhjem District (Ombygningen av Indherred sykehus i Nordre Trondhjem's amt.). Dr. O. Tandberg. Tidsskr. f. d. Norske Laegefor., 1917, XXXVII, No. 5.

The Indherred Hospital was built in 1842. It was a wooden structure with room for 50 beds. For many years past it was overcrowded. In 1913 the district decided to erect a new structure in a line and connected with the old building. It was completed in 1916, and is a substantial three-story stone building capable of housing 60 patients. The three stories are traversed in their full length by a central corridor. An isolation pavilion for infectious diseases contains two sick rooms with four beds each. The total expenses for the new structure were 315,500 crowns (\$47,325).

Apparatus for Writing With the Knee. Arthur T. Blachly, M. D. Jour Am. Med. Assn., 1917, LXVIII, No. 23.

Dr. Blachly describes an apparatus designed to permit persons who have lost their hands, or the use of them, to write legibly with their knees. The apparatus consists of a piece of sole leather fastened to the knee by strong brass springs on which is fastened a pencil by means of two clips, such as are used in holding a pencil to the pocket. The paper is held in front of the writer by means of a small rack like a music rack. In writing, the heel is raised and the foot, resting on the pulley, gives the knee quite a wide range of motion. A stylographic fountain pen can be used as well as a pencil. The device, it is said, is inexpensive. The model cost \$1.50; if the springs were replaced by straps the cost could be reduced to \$1.10. The method would appear to be more convenient than holding a pencil between the teeth or toes.

Opening of the First Antituberculosis Sanatorium at Biassono (L'inaugurazione del primo asilo antitubercolare a Biassono). Ospedale Maggiore, 1917, IV, No. 10.

Children of tuberculous parents are so easily infected with tuberculosis that the only means to protect them against infection is to remove them from their dangerous surroundings. But even after infection has taken place the lives of the children can be saved if they are placed in healthful surroundings. For these reasons the Milan Society for the Prevention of Tuberculosis in Children has established a sanatorium for children at Biassono, a little village near Milan. At first it was intended that the institution should receive only babies of tuberculous parents, but later it was decided to take in also larger children who showed signs of initial tuberculosis. The sanatorium is situated in a very healthy region and is splendidly adapted for heliotherapy. A Montessori school is connected with the institution.

The Window of the Bedroom (Het venster van de bedvertrek). Dr. G. C. van Walsem. Ziekenhuis, 1917, VIII, No. 3.

The windows in many hospitals, and especially in hospitals for mental diseases, are improperly constructed. The author proposes the following form: The window consists of two portions. The upper part takes in the upper third. It is hinged on its base and opens inward. The sides are closed by flexible thick cloth. This portion serves for ordinary ventilation. The lower part of the window takes in the lower two-thirds and consists of two vertical wings hinged on the sides and meeting in the middle. This part serves for a thorough and complete renewal of the air in the room whenever necessary. To modify the light, blue window shades are attached to each

portion of the window. In order to keep the shade of the upper portion in place when the window is opened, the shade runs on guide poles fastened on each side.

The Use of Saccharine in Hospital Pharmacies (Uso della saccarina nelle farmacie ospitaliere). Ospedale Maggiore, 1916, IV, No. 12.

As sugar is at present scarce and very expensive in Italy, the minister of finance, at the request of the hospital superintendents, has issued a circular in which he gives permission to hospital pharmacies to use saccharine instead of sugar in the preparation of all prescriptions as well as for sweetening simple syrups which the pharmacies prepare in large quantities for various uses. But, whether the hospital pharmacies obtain this saccharine from large pharmaceutical companies or import it directly from foreign countries, they are required to keep exact registers with regard to the amount of saccharine used in the various preparations.

Halazone for the Sterilization of Water.—In the *British Medical Journal* of May 26, 1917, p. 682, Dr. H. D. Dakin and Major E. K. Dunham (U. S. Army) described the preparation of parasulphondichloraminobenzoic acid and its value as a disinfectant for polluted water. This product was finally chosen because it can be used for the purpose indicated in a single tablet, the inconvenience of the double tablet method having already been amply demonstrated. The systematic chemical name being evidently too unhandy for ordinary use, these authors proposed the name "Halazone" for the substance and suggested that it should be put up in tablets, each containing 4 mg. This suggestion has now been carried out. The product is marketed in compressed tablets containing 4 mg. of the disinfectant, the quantity stated by Dakin and Dunham to be sufficient to sterilize a liter or quart of reasonably heavily contaminated water; in the case of extreme contamination a second tablet may be necessary. The tablets dissolve gradually in about five or ten minutes, and the water should be allowed to stand for about forty minutes before use. The tablets must be kept in amber bottles and not exposed to sunlight; under those conditions they are stable. They are supplied to the medical profession in bottles of 100 at 8 pence (16 cents) each in the United Kingdom. In the United States the same quantity costs 25 cents, but a vial containing 1,000 tablets costs only \$1.

Chloramine-T Paste in the Treatment of Wounds.—The *Journal of Experimental Medicine* of July 1, 1917, contains three articles dealing with chloramine-T paste for the treatment of infected wounds and for the maintenance of asepsis of noninfected wounds. The best composition for the paste was ascertained to be: Neutral sodium stearate 86 gm.; chloramine-T, 10 gm.; distilled water, 1,000 c. c. The results may be summed up as follows:

Slightly infected wounds may be completely sterilized by the use of this paste in 35 percent of the cases and, in a much larger proportion, sufficiently so to permit of suture. It is useless to attempt to sterilize a profoundly infected wound by means of a paste. For this purpose an antiseptic solution frequently renewed must be employed. Chloramine-T paste, though relatively stable, cannot be depended upon to maintain its strength for more than one month. The use of the paste does not *per se* either retard or hasten the process of cicatrization.

BOOKS RECEIVED FOR REVIEW

The International Military Digest. Annual. A Review of the Current Literature of Military Science for 1916 Cumulated from the Monthly Issues of The International Military Digest. Pp. 630. Cloth. Cumulative Digest Corporation, New York City, 1917.

The Causes of Tuberculosis. Together With Some Account of the Prevalence and Distribution of the Disease. By Louis Cobbett, M. D., F. R. C. S., University Lecturer in Pathology, Cambridge. Pp. 707. Cloth, price \$6.50. Cambridge University Press, 1917.

The Edith Cavell Nurse from Massachusetts. A Record of One Year's Personal Service With the British Expeditionary Force in France, Boulogne-The Somme, 1916-1917. With an Account of the Imprisonment, Trial and Death of Edith Cavell. Pp. 95. Boards, price \$0.60. W. A. Butterfield, 59 Bromfield St., Boston.

Physical Exercises for Invalids and Convalescents. By Edward H. Ochsner, B. S., M. D., F. A. C. S., President Illinois State Charities Commission; Attending Surgeon Augustana Hospital, Chicago. Pp. 54. Flexible cloth, price \$0.75. C. V. Mosby Company, St. Louis, 1917.

State Board Questions and Answers for Nurses. Being the Actual Questions Submitted at the Examinations of 31 State Examining Boards for Nurses, with Answers. By John Foote, M. D., Assistant Professor of Therapeutics, Georgetown University Medical School, and Pediatricist to Providence Hospital, Washington, D. C. Pp. 398. Cloth, price \$2.50. J. B. Lippincott Company, Philadelphia, 1917.

Medical Diseases of the War. By Arthur F. Hurst, M. A., M. D. (Oxon.), F. R. C. P., Temporary Major R. A. M. C.; Physician and Neurologist to Guy's Hospital; Neurologist to the Royal Victoria Hospital, Netley; Lately Member of the Medical Advisory Committee, Mediterranean Expeditionary Force, and Consulting Physician to the Salonica Army. Second Impression. Pp. 151. Cloth, price \$1.75. Edward Arnold, London, 1917.

Roentgen Technic (Diagnostic). By Norman C. Prince, M. D., Attending Roentgenologist to the Omaha Free Dental Dispensary for Children; Associate Roentgenologist to the Douglas County Hospital, Bishop Clarkson Memorial Hospital, Swedish Immanuel Hospital, St. Joseph's Hospital, and Ford Hospital, Omaha, Neb. Pp. 137. With 71 original illustrations. Cloth, price \$2.00. C. V. Mosby Company, St. Louis, 1917.

The Treatment of Emergencies. By Hubley R. Owens, M. D., Surgeon to the Philadelphia General Hospital; Assistant Surgeon to the Philadelphia Orthopedic Hospital and Infirmary for Nervous Diseases; Chief Surgeon to the Philadelphia Police and Fire Bureaus; Assistant Surgeon Medical Reserve Corps, U. S. Navy. Pp. 350, with 249 illustrations. Cloth, \$2.00 net. W. B. Saunders Co., Philadelphia and London, 1917.

Advice to Women on the Care of the Health Before, During, and After Confinement. With Hints on the Care of the New-Born Infant, and an Appendix on What to Get Ready for a Baby. By Florence Stacpoole, Diplomée of the London Obstetrical Society and Lecturer to the National Health Society, author of "Our Sick, and How to Take Care of Them," etc. Revised from the fifth London edition, to conform to American practice, by Lydia E. Anderson, R. N. Pp. 265. Cloth, price \$1.25 net. Funk & Wagnalls Company, New York, 1917.

Essentials of Dietetics in Health and Disease. A Text-Book for Nurses and a Practical Dietary Guide for the Household. By Amy Elizabeth Pope, formerly instructor in the School of Nursing, Presbyterian Hospital; instructor in School of Nursing, St. Luke's Hospital, San Francisco, Cal.; author of "Quiz Book of Nursing," "Anatomy and Physiology for Nurses," "A Medical Dictionary for Nurses," and, with Anna Maxwell, of "Practical Nursing"; and Mary L. Carpenter, Director of Domestic Science of the Public Schools, Saratoga Springs, New York. Second edition, revised and enlarged. Pp. 379. Cloth, price \$1.25. G. P. Putnam's Sons, New York, 1917.

NEW INSTRUMENTS AND EQUIPMENT

VINCENZ MUELLER, Technical Editor.
GEO. W. WALLERICH, Associate Editor.

Please address items of news and inquiries regarding New Instruments and Appliances to the editor of this department, 327 Southeast avenue, Oak Park, Illinois.

Adjustable Crutch

The adjustable crutch shown will especially appeal to the superintendents of the public and charity hospitals where it is customary to supply the patients with the necessary crutches without charge. Instead of having to

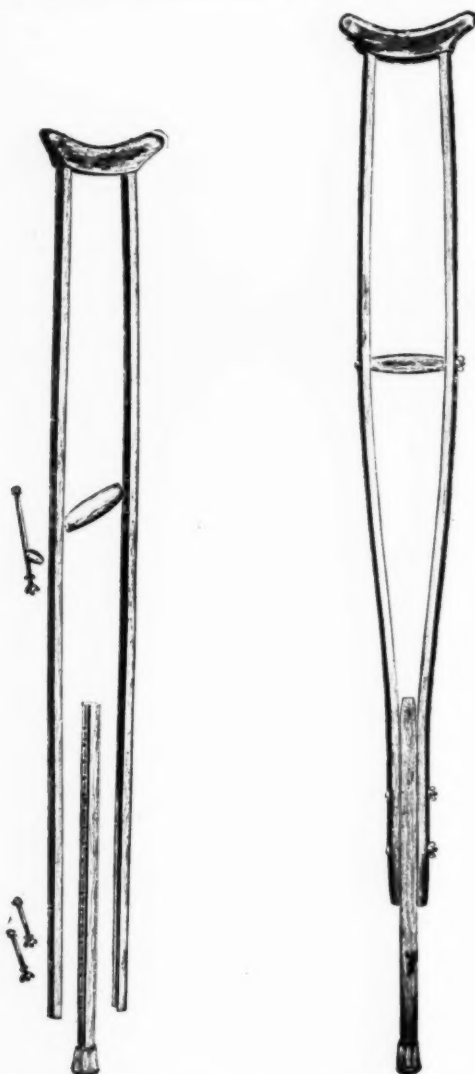


Fig. 1. Showing individual parts of adjustable crutch.

Fig. 2. Adjustable crutch assembled.

keep on hand a stock of crutches of from fifteen to twenty sizes, it will be necessary to carry only a few sizes for children and youths, and practically only a number of

crutches of one size for adults, inasmuch as the adult-size crutch can be extended from 45 to 60 inches. The handle as well as the lower extension piece can be adjusted in a few minutes. The lower portion is grooved so that, when the three parts are bolted together, it makes a firm and reliable appliance. For use in army hospitals this crutch should also be of great service. The price of the device is very reasonable, and surely will result in a considerable saving in the course of time. The crutches may be procured at the surgical instrument supply houses.

The Connell Gas-Oxygen-Ether Apparatus

Dr. Karl Connell, assistant surgeon to Roosevelt Hospital, New York, well known through his work of investigation in anesthetics, recently presented before the New York Society of Anesthetists an apparatus for the administration of nitrous oxid-oxygen-ether which has been built in accordance with his ideas. Through his extensive experience in the use of probably all apparatus, Dr. Connell has had unusual opportunity for studying the shortcomings of many devices.

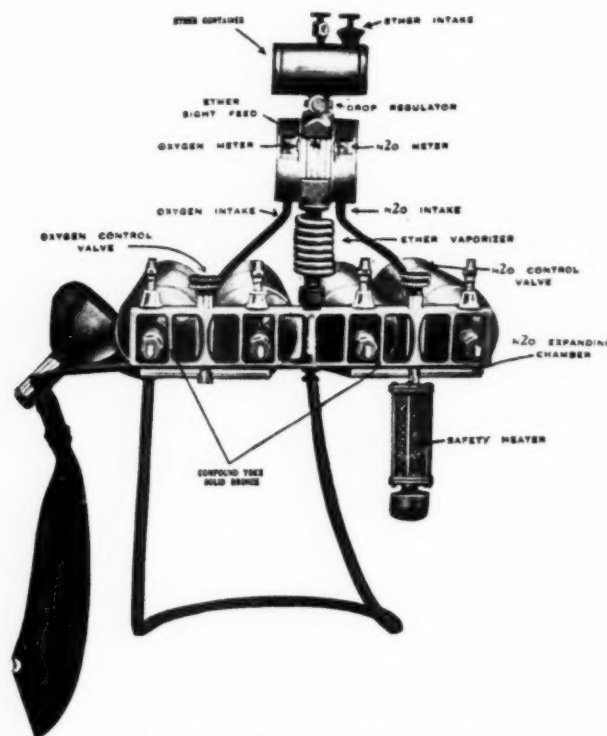


Fig. 1. Connell gas-oxygen-ether apparatus.

In designing his apparatus Dr. Connell has successfully overcome the one great drawback in the control of the gases, namely, that exact knowledge may be had of the amount of nitrous oxid or oxygen being delivered, and this without the necessity of making calculations, using liquids or oils in gravity manometers, or making allowances for any differences in tank pressures.

One of the first models which Dr. Connell devised and which was used for several years at Roosevelt Hospital, was provided with a piston traveling in a cylinder, this piston being actuated by pressure from the cylinder, and uncovering a calibrated slit for gas escapement. The disadvantage of this arrangement was that the piston would at times stick in the cylinder. Further experimentation led to the development of the use of an unbalanced vane or disc, on the periphery of which gas impinges, actuating the disc against the force of gravity. By riding the disc

on fine gold pinions in ruby jewel bearings, minute variations to a fraction of a teaspoonful of gas per minute are obtainable. A scale is attached to the disc and can be observed through a glass window of the housing, giving a direct reading of gas flow. The oxygen disc is calibrated to a flow, in steps of liter per minute, from 0.2 to 2.5 liters per minute. The nitrous oxid disc is calibrated in steps of 1 liter per minute from 2 up to 12 liters per minute.

These meters are about the size of a large watch.

While the meters and control are of first importance, other parts have been worked out with equal care.

Contrary to most methods of cylinder mounting, the cylinders are placed on their sides, two of oxygen and

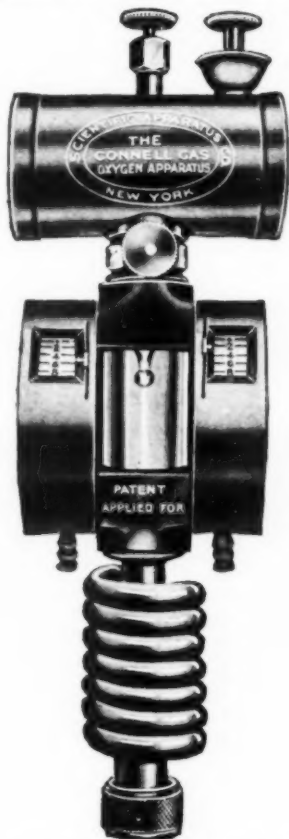


Fig. 2. Connell ether container, meters, and vaporizing tube.

two of nitrous oxid. They are connected by means of a one-piece bronze yoke. The control valves are seated in the yoke and can be manipulated with but little effort.

An alcohol lamp, which has safety features eliminating any possibility of ignition of ether vapor or liquid, is attached to the nitrous oxid side. Mounted above the meters is a container for holding ether. A sight-feed drop valve allows the ether to drip into a vaporizing coil shown in the illustration, whence it is sent into the yoke and on to the patient. The weight of the apparatus is but 7 pounds, exclusive of cylinders.

No special table or stand is required, but any convenient support, such as a chair, dressing table, or stool may be used, as found best suited to the case in hand.

Motor-Driven Plaster-of-Paris Saw

The removal of plaster-of-paris casts has always been one of the operations which the chief gladly turned over to be performed by his assistant, we therefore believe that the chief, the assistant, and even the hospital orderly will

hail with delight the advent of the electrically-driven plaster-of-paris cutter. Such an apparatus is now offered to the surgical profession under the name of the electro-surgical cutter. The apparatus consists of an electric motor, the shaft of which extends at one end and has

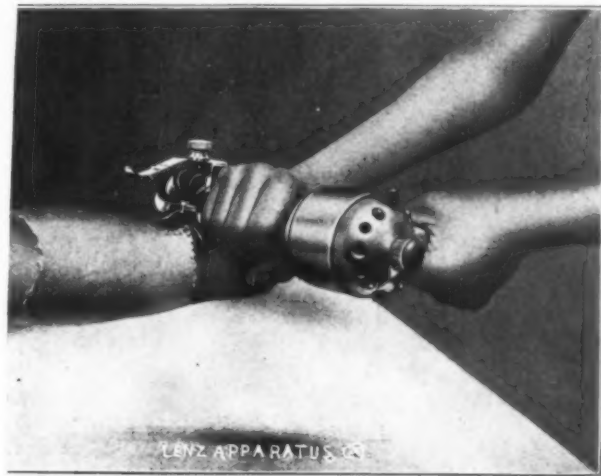


Fig. 1. Electrically driven plaster-of-paris saw in operation.

coupled to it a stem to which a rotary cutting knife is attached. The knife has concave cutting edges so arranged that it will cut clear, thus automatically making clogging or stopping of the motor impossible. A guard over the knife protects the operator from injury as well as dust and flying particles while the apparatus is in operation.



Fig. 2. Showing plaster-of-paris cast cut by means of electrically driven apparatus.

ation. A handle extending at right angle from the motor permits of a firm grasp, carrying near one end a push-button by which the motor may be started and stopped instantaneously.

The motor-driven apparatus eliminates the irregular jerks of movement so common when hand-operated devices are used, and the toughest plaster-of-paris dressing can be removed with surprising rapidity and without the least discomfort to the patient.

Miss Edith Mutch and Miss I. J. Masters have lately taken the positions of directress of nurses and night supervisor, respectively, at the Brownsville General Hospital, Brownsville, Pa.

LETTERS TO THE EDITOR

Colored Pupil Nurses

To the Editor of THE MODERN HOSPITAL:

I notice your article (July, 1917, p. 72) relative to colored pupil nurses. Though we are not in a middle state, we would like it known that we are maintaining a nurse training school and would be glad of more desirable applicants for our work, beginning September 1.

F. BELLE RICHARDSON,
Superintendent Hale Infirmary and Nurse Training School, Montgomery, Ala.

Another Problem in Economy

To the Editor of THE MODERN HOSPITAL:

Although it is known to everybody that hospital costs have gone up almost to prohibitive points, some of the members of our hospital communities are demanding that we take care of all free cases that come, without reference to the proportion of free cases to paying patients. The argument is that "the people are sick and must be taken care of." What are we to do about it?

A SOUTHERN HOSPITAL.

The settlement of this problem will require probably more courage on the part of the superintendent than almost any other problem in the hospital management because, in the reasoning of your hospital public, you are "turning a deaf ear to the call of distress"—and that is a hard thing to do. As a matter of fact, your hospital public are not paying you for your philanthropies or for charities; they are paying you to run their institution in a businesslike way. They have a right to expect that you will administer your trust along sane business principles, and it is not according to business principles to engage to do a thing or to attempt to do a thing for which you have no funds. The thing for you to do is to be quite sure to reserve enough beds, in rooms and wards in your hospital, allowing for, say, 25 percent of unoccupied time, to meet your expenses in full, and then, if there are beds over and above that number, and if there are funds to support those beds, it is all right for you to take in free patients. Otherwise, it is your duty to demand of your public and your board the necessary funds to do your work with.

You will have to handle this matter in an adroit, tactful but very courageous way or you will have a lot of trouble.

A Plea for Married Institutional Physicians

To the Editor of THE MODERN HOSPITAL:

Owing to the present unsettled conditions due to the war, and the apparent scarcity of physicians for institutional positions, I believe this a timely topic for consideration. Many of the younger doctors are offering their services to their country, and a much larger number will be required to meet the needs of modern warfare should our country unhappily have to bear the brunt of the fighting, as the present conditions would seem to indicate. A large proportion of these medical men will be taken from institutions, because statistics prove that candidates having had institutional experience seem to be preferred for government services. How are these hundreds of vacancies going to be efficiently filled?

From a compilation of institutional records it is surprising to note the great preponderance of single physicians occupying institutional positions. From personal experience, and from the observation of others, it is also appalling what a scarcity of institutional openings there are suitable for married physicians. What is the reason for this state of affairs; and is it justified from the point of view of true economy and efficiency?

About 90 percent of the physicians of the United States get married within five years after their graduation, which means that the average doctor will occupy the average institutional position, outside of his intern year, four years. After that he will seek something that will allow him to enjoy a normal married life as do other human beings. During his institutional career he may have become especially proficient in some particular line of work characteristic of that institution. If he is a capable man he will have become as efficient and useful as at least two green men, and his employers will by this time have measured his future capabilities, his honesty, and his reliability—all of which are of very great importance in institutional work of a responsible nature. Is this worth anything to the superintendent of a hospital or sanatorium?

In the legal profession, especially corporation law, it has been found that the longer a lawyer is connected with a concern the more familiar he becomes with the corporation's needs and policies and the more valuable do his services become. In most industrial pursuits long-time service is encouraged, because it promotes true economy and efficiency.

A doctor and a machinist, after all, have only a broad knowledge each of his profession and trade, respectively. But the doctor with large experience in, let us say, laboratory and pathological work, is certainly of far greater value to the laboratory of a large general hospital or insane institution than is his brother who has just completed a service on the wards of a surgical hospital. So, too, the machinist; he is of far greater value to the maker of gasoline engines if he has had special experience along that line than he would be to the maker of looms.

To put the proposition another way: as superintendent of an institution is it of any value to you to know positively that your subordinate is to be relied upon during your absence, that he is competent and reliable to bear a large share of your burdens should misfortune unhappily befall you? All these points have been very carefully considered by modern business institutions. If a permanent employee is of greater value to them than is the continuously shifting help, why is it not equally valuable—even more so—to an institution which is, strictly speaking, nothing more or less than an unproductive business concern, usually handicapped by a limited capital? Do you know, outside of the medical profession, of any other industrial or professional institutions that depend upon trained help which close their doors to a valuable man because he is married? Of late many hospitals for the insane have found it far more profitable to engage married than single attendants. Are doctors any less important, are the quarters provided them, as a rule, any more comfortable than those provided for attendants and their wives?

Some of the reasons given by institutional men for preferring single men are the following:

First, lack of room is alleged. This objection may be based on good grounds in some instances, but in many others it is entirely unfounded. The experience of going through the various stages of orderly, nurse, clerk, intern, and assistant to the superintendent, in sixteen different institutions, together with a careful study of many in which I was not employed, gave me very excellent reason to make the statement that in only one of these institutions was every room economically utilized, thus making room for a married physician absolutely impossible. In a great many institutions I found rooms most uneconomically utilized, and yet when the question of a married physician came up the superintendents almost invariably gave the excuse that there was no room.

Another objection to married physicians is often founded on the close social relations of the doctor to patients and nurses. These objections, although oftentimes well founded, are really no more pertinent in institutional work than in private practice. As a matter of fact, the compatibility or incompatibility of a physician's wife to institutional life is purely an individual problem. Each case should be judged on its own merits. I venture to say, however, that the experience of many who are employing married physicians bears me out that the objections thereto are greatly exaggerated and the benefits therefrom are apt to be overlooked.

To the married physician with a leaning towards institutional work, the present situation is very depressing. Take my own case as an illustration; from mere boyhood on I did institutional work in various capacities; I was given courteous treatment and encouragement to work my way through college and medical school. Upon leaving an institution the superintendent many times expressed regret at losing an efficient and reliable employee; many expressed hopes that I would return when in need of a position. After I graduated, alas, I committed the sin of getting married. That temporarily ended my institutional career. I found that those who had employed me previously now could not possibly find room for me. In my hunt for suitable institutional work I found that nine out of every ten positions were closed to married men. Today, although I have a broader training, am more efficient, and would be of far greater value to any institution than I was then, I am obliged to live apart from my family and lead an irregular life in order to work at that branch of my profession for which I am best fitted by experience and training. Is any thinking physician that cares for his family going to lead such a life permanently, or is he going to await the opportunity for something to show up that will enable him to make a living without disrupting his family? Is the institution employing me going to profit by losing an experienced man and hiring in his place one that is, ten chances to one, not familiar with the details of the work; who may turn out unreliable, dishonest, intemperate or otherwise unfit for institutional work; or, if found qualified, will only fill the position during a maximum period of four years, if he is one of the ninety out of the hundred average physicians, before he, too, commits the sin of getting married?

Think this over, you institutional managers, superintendents, and trustees, and you will find that in the long run a married physician will be a better asset to your institution than two single ones.

CARL SCHEFFEL, PH. B., M. D.,
Coolidge Corner, Mass.

A new home for the Chicago Lying-In Hospital, to be known as the James Hobart Moore Memorial, was opened July 28. The building, which is a seven-story fireproof structure, was made possible largely through a gift of \$100,000 from Mrs. James Hobart Moore. Construction work was started three years ago, but because of the war and the ensuing financial uncertainty completion was delayed. Accommodations have been provided for 120 mothers and as many babies. The equipment of the new hospital is said to include the latest improvements in everything that science offers for the operation of such institutions.

Drs. Pearse and Cooley opened new quarters for their private hospital at Brigham City, Utah, in August.

HINTS FOR HOSPITAL SUPERINTENDENTS

The Benevolent Autocrat

"My board does not ask for my opinion," is the remark that we often hear superintendents make. Somehow the remark fails to find a response in the minds of most of us; there is generally a reason why a board of trustees does not ask for the opinion of its superintendent. Hospital trustees, medical staff members, and the responsible supporters of a hospital are usually not well versed in administrative matters. All these people are seriously interested in the affairs of the institution with which they are associated and nearly always seek really serviceable information, the exceptional case being where someone has some personal "ax to grind." If a superintendent stands up sturdily to meet his or her problems with wisdom and judgment and tact, and if he or she finds a smooth way over the rough places, it will not take a board of trustees or the members of a medical staff very long to find out that that superintendent knows what he or she is talking about and doing, and very soon all apparently insoluble problems of the trustees and the medical men will be brought to him or her for solution.

If a board of trustees or a medical staff is running a hospital, giving the superintendent orders, without much regard to what he or she may think about the wisdom of those orders, it can be pretty confidently assumed that it is the superintendent's fault and not that of the trustees or medical men.

Hospital Architecture and the New Trustee

Most of the monstrosities in the shape of so-called modern hospitals are to be credited to enthusiastic new trustees of hospitals. When a trustee is first elected to a hospital board his enthusiasm known no bounds, and it generally takes him about thirty days to become an expert hospital man. The first thing he wants to do is to make some plans, and the shorter the time that he has served as a trustee, generally, the less likely is he to be willing to take advice from the superintendent of the hospital or from anybody else. If a trustee at this stage of his career is not headed off he is likely to perpetrate one of the architectural monstrosities that we see scattered all over the country. His course generally is to bully the architect, and, having done this, the rest of his crime is easy.

If trustees of hospitals used the same good, hard, common sense that has served them to build up successful private business and has made them prominent in their communities, we would have better hospitals in this country; but to a great many men, and women, too, the hospital is a hobby horse, and once seated in the saddle they become princes of joyriders.

Gasoline for Cleansing Wounds

In cases of injuries due to railroad or shop accidents the wound areas are usually soiled with a great deal of grease and dirt, which must be removed from the area of the wound before iodine can be applied and the wound dressed. A gasoline-soaked sponge does the work quickly without the irritation to the parts that scrubbing with green soap and a brush produces. Gasoline is a thorough disinfectant and much cheaper than many others.

It is a good practice to keep a bottle of gasoline handy in the dressing room. It takes up little space and is always ready.

I. MORTON, R. N.,
Colorado Springs, Colo.

DANGER IN DRAFTING MEDICAL STUDENTS AND INTERNS

Resolutions of the New York Mayor's Committee on Hospital and Medical Facilities

At a meeting of the Mayor's Committee on Hospital and Medical Facilities, held at City Hall, New York City, on August 15, 1917, the following resolutions were unanimously adopted:

Resolved, That the Mayor's Committee on Hospital and Medical Facilities call the attention of the Secretary of War to the serious consequences to the civilian population of the country and to the maintenance and operation of the hospitals, of the inclusion of medical students and hospital interns under the act for selective service.

Further Resolved, That the chairman be directed to lay the views of this committee before the proper officials of the government and the district boards of the state of New York, and to take the necessary steps to bring about the temporary exemption of these students and interns in order to secure a constant supply of medical men to the army throughout the war and to prevent the embarrassment of hospitals and the consequent serious results to the population of the United States.

The following named hospitals were represented at the meeting: New York Hospital, Presbyterian Hospital, Manhattan Eye, Ear, and Throat Hospital, Lebanon Hospital, Mt. Sinai Hospital, Brooklyn Jewish Hospital, Long Island College Hospital, Brooklyn Hospital, Italian Hospital, French Hospital, Columbia University, Roosevelt Hospital, St. Luke's Hospital, Post-Graduate Hospital, Swedish Hospital, St. Francis Hospital, Lincoln Hospital, German Hospital of Brooklyn, Columbus Hospital, Staten Island Hospital, Polyclinic Hospital, New York Orthopedic Hospital, Hospital for Deformities and Joint Diseases, Metropolitan Hospital, Kings County Hospital, Bellevue Hospital, City Hospital, Willard Parker Hospital, Kingston Avenue Hospital, Riverside Hospital, Montefiore Home, United States Naval Hospital.

THE "INSTITUTIONALIZED" INSANE

With Incentives to Normal Life Lacking, Few Could Remain Sane—Necessity of Preserving Normal Stimuli in Institutions for the Mentally Deranged

"That inhuman thing that is connoted by the term 'institutionalism,'" says Dr. Mary Lawson Neff in an article published in the *Journal of the American Medical Association*, "has brought about conditions under which none of us could remain normal." She describes the following incident, from which her own personal interest in efforts to "normalize" the life of the insane dated.

"Passing through a ward where flowers, sunlight, air and pleasant furnishings gave a superficial appearance of comfort, my attention was called to the patients. These were sitting on either side of the corridor in straight rows, interrupted here and there by a potted plant, or by a 'sacred' sofa pillow on which human head had never lain. This row, the chairs all alike, and the faces all turned the same way, left nothing to be desired from the standpoint of geometry. With hands folded, often with eyes closed, not one of these people showed any gleam of interest in life. I stopped to speak to a sweet little white-haired woman, saying, 'Why don't you people find something to do? Can't you play games, or read aloud, or something? You can at least break up this row, and turn around and talk to each other!' The reply, given in a perfectly colorless voice, was, 'We are not allowed to turn around. The matron thinks we look neater sitting this way.' Then

and there I determined to study my problem from the patient's point of view; and as I studied it thus, there grew a deep conviction that the cruelest thing that comes to these thousands of fellow-beings whose lives are spent shut away from the world is ennui—the unspeakable ennui of hours and days and months and years, colorless beyond anything we can imagine."

Normal life, Dr. Neff continues, is largely a series of responses to the three stimuli furnished by necessity, ambition, and the family affections. The institutional patient is suddenly and effectively cut off from all three of the motives that actually make life, and in this abnormal environment we quite naturally find that after a time we have a mental condition that is a blend of the original psychosis and the "psychosis of abnormal living."

There are four main reactions to prolonged ennui: apathy, violence, untidiness, and the elaboration of delusions, fears and obsessions, until the normal possibilities of the patient are lost in perverted mental activities that obliterate everything else.

The problem, then, in hospitals for the insane, is to find normal stimuli, incentives, rewards, and human reactions for people whose horizon is contracted. The "normal areas" of the patient's mental life are the ones on which to base his treatment, rather than the abnormal ones.

Since the major stimuli of life are lacking, the minor ones must be utilized to the fullest possible extent. Every method of stimulating ingenuity, inventive ability, esthetic work, or self-expression of any kind, should be employed. The play-motive may be used advantageously to a large extent; through it the patient with the mental status of a child may best be led to more serious forms of employment.

Altruism can be developed to a degree surprising to anyone who has not actually attempted the work. A group of discontented patients was once transformed by "adopting" an orphan asylum for whom hundreds of little garments were made. In another hospital a society of patients calling themselves "The Helping Hand" spends certain afternoons working for the less fortunate wards.

The activities furnished for patients should be as normal as possible in every way, including carefully adapted methods of teaching, a variety of work, liberal provision for recreation, respect for the "personal equation," reward for the work performed, and a "therapeutic disposition of the product."

The assumption that the unfortunate patient with mental symptoms has "forfeited his industrial status" seems hardly tenable. The late Prof. C. R. Henderson, of the Department of Economics in the University of Chicago, admirably expressed the proper point of view by saying, "What should be the patient's occupation, and what should be the disposition of his earnings, should be determined by medical authority, with sole reference to its effect on his health." The economic gain in transforming the violent patients into tractable ones, the untidy into neat ones, the destructive into productive ones, and the unhappy into happy ones, which follows a well-planned occupation movement, is very great, even where patients are given, as is done in some institutions, all the proceeds from such work as can be sold. This fact is of importance in seeking legislation which will make further advance in this field possible.

The beginnings already made are fruitful and encouraging, and it is hoped that soon the institution for the insane shall be a protected community of people living as normally as possible.



Things that are Worth Learning

Among the dishes which the nurse likes to prepare are the refreshing and attractive jelly salads of which the foundation is Jell-O. These are made by adding to the Jell-O, before it begins to congeal, chopped celery and apple, and walnut meats broken into pieces and salted. They are moulded in teacups or little moulds and each is turned out on a lettuce leaf.

Such a dish may be called a salad or a dessert, and it is good as either.

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for her dainty dishes is never obliged to depend upon luck. She can, easily and confident of success, do what she used to do with tedious detail and with qualms as to the outcome.

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NEWS OF THE HOSPITAL FIELD

Eastern States

The Saratoga Hospital, Saratoga Springs, N. Y., is making an effort to raise \$50,000 for improvements.

Plans have been filed by the Buffalo General Hospital, Buffalo, N. Y., for a new home for its nurses, to cost \$174,000.

A permit was issued to the Mercy Hospital, Altoona, Pa., on July 28, for the erection of a 14-story and basement addition to cost \$52,000.

The will of Charles W. West, filed for probate in Brooklyn on August 10, directs that the bulk of an estate thought to exceed \$100,000 be given to the Long Island College Hospital for research in medicine and surgery.

The Knickerbocker Hospital, New York City, has filed plans for a new six-story building to cost \$350,000. Accommodations will be provided for 400 patients, half of this number to be cared for in private rooms.

A new maternity building will soon be opened by the Warren Emergency Hospital, Warren, Pa. The building is a complete unit, equipped to accommodate 20 patients. It is a gift from J. P. Jefferson, of Warren, in memory of his wife.

A new superintendent has lately been installed at St. Agnes Hospital, Baltimore, Sister Gertrude, of Buffalo, succeeding Sister Gonzaga in that position. Sister Gonzaga has returned to the novitiate of the Sisters of Charity at Emmitsburg, Md.

Grace Hospital, New Haven, Conn., has awarded contracts for a new two-story and basement building to contain heating and power plant, laundry, morgue, garage, and servants' quarters. The cost of the structure will be approximately \$90,000.

The Robert Kopp mansion in York, Pa., erected in 1917 at a cost of \$100,000, has recently been purchased by Dr. Edwin Downing and Dr. J. E. Barrick, osteopathic physicians of York, who will convert the building into a sanatorium for mental and nervous diseases.

Architects Helmle & Corbalt, of Brooklyn, have been instructed to proceed with working drawings and specifications for a new home for the Williamsburg Hospital in that borough, and it is stated that the construction will be begun as soon as this work is completed. The building will have a capacity of 150 beds.

William Breiting, of Harrisburg, Pa., was elected general manager of the Lancaster General Hospital, Lancaster, Pa., at a meeting of the board of directors of that institution held August 13. Miss Edna C. Taylor, who has been serving the hospital as superintendent, will remain as superintendent of nurses and of the training school.

The City Council of Buffalo, N. Y., on the mayor's recommendation, has adopted an ordinance consolidating the city's three hospitals and five dispensaries in one bureau, with Dr. Walter S. Goodale, superintendent of the present municipal hospital system, as executive official. A new hospital with a capacity of 1,000 beds will be opened by the city of Buffalo this fall.

The Medico-Chirurgical Hospital, Philadelphia, has been taken over by the American Red Cross for a naval base hospital, the entire staff of physicians and nurses being retained. The building has been condemned by the city to make way for a new parkway, but will be allowed to stand



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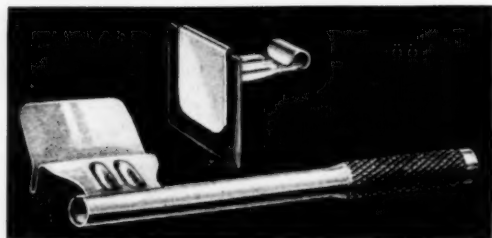
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until the end of the war. A new home will be erected for the Medico-Chirurgical Hospital.

John K. Tener, ex-governor of Pennsylvania, is in charge of a project of the Benevolent and Protective Order of Elks to provide hospital care for sick or wounded soldiers and sailors of its membership and to care for widows and orphans of members who may be killed in the war. The order has appropriated \$1,000,000 for this work.

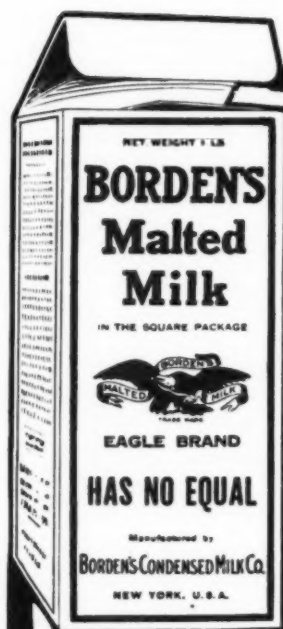
The Sisters of St. Francis, on August 3, formally took over the general management of the Mary Keller Memorial Hospital, Scranton, Pa., in which they have had charge of the nursing department since the hospital was opened over a year ago. The institution is housed in a new building of modern construction and equipment representing an investment of \$100,000.

The Babies' Hospital, of Philadelphia, has recently acquired several lots at South Seventh and DeLancy Streets, that city, as a site for a dispensary building, for the erection of which Mrs. Edwin D. Douglas last year donated \$50,000. The building will contain clinical and examination rooms for patients, and lecture rooms, where lectures upon the care of babies, prenatal as well as after their birth, will be given for parents. There will be a ward containing eight beds on the top floor for emergency cases or cases which the hospital authorities may want to keep under observation, or for such cases as are found to be too ill to be moved after examination in the clinics. There will also be a roof garden, with cots for the comfort of mothers and babies. The dispensary will cooperate with the medical colleges of the city and with the child welfare organizations.

The New York City Hospital Board, of which Dr. Robert J. Wilson, superintendent of the Willard Parker Hospital and president of the American Hospital Association, is the head, has recently completed plans for what is said will be the largest contagious disease hospital in the world. The hospital is to occupy the block bounded by Schieffelin Place, Seton Avenue and East 233d Street, The Bronx, and will have a capacity of 1,000 beds. The building will be four stories high, surrounded by a porch at the level of the third floor. A kitchen, dining room, laundry, rooms for physicians and nurses, treatment rooms, and two wards will occupy the ground floor. On the next floor will be the admission and discharge rooms, information office, waiting rooms, and more than 20 glass-walled observation rooms. The third floor will be divided into four wards, convalescent rooms, a diet kitchen, and baths. Living, rest, and recreative quarters for the resident and visiting staff are to be provided on the top floor.

With a view of mobilizing all the resources which will assist the counties of New York in carrying out the provisions of the recently enacted law requiring the construction of tuberculosis hospitals in counties of 35,000 population or more, the State Commissioner of Health, Dr. Hermann M. Biggs, has appointed two committees, which are to take entire charge of the tuberculosis situation in this state. The first committee will have general supervision of the sites, plans, construction, and equipment of tuberculosis hospitals, and will carry on the antituberculosis campaign in the state. On this committee are Dr. John A. Smith, Dr. O. R. Eichel, Dr. E. S. McSweeney, with Dr. Matthias Nicholl, Deputy Health Commissioner, as a member of the committee ex-officio, and also a construction and an engineering expert. The second committee is an advisory committee, consisting of Dr. Albert H. Garvin, Dr. John S. Billings, Dr. Charles Stover, Dr. Horace J. Howk, and Dr. Lawrason Brown.

Plans for the James Buchanan Brady Foundation of Urology to be established in connection with the New York Hospital, New York city, have been made public following a settlement of the contest of the will of Mr. Brady, who died last February, leaving the bulk of his \$3,000,000 to charity. Temporarily the work of the foundation will be carried on in the laboratories of the New York Hospital, but the trustees plan to erect in the near future a six- or eight-story building costing about \$500,000. The foundation, which will be under the direction of Dr. Oswald S. Lowsley, will afford exceptional clinical facilities, and will give much attention to research. There will be endowed departments along chemical, physical, bacteriological, and pathological lines, affording a free advisory



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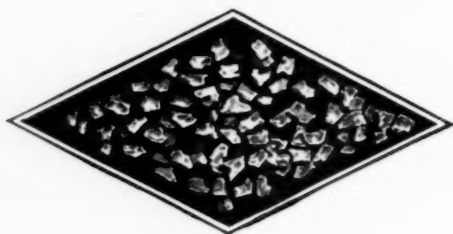
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clinic for the physicians and scientists. A urological library of 5,000 volumes, and a museum of tabulated and photographed specimens are to be provided. The staff will include five resident and twenty-three dispensary physicians, together with seventy-five nurses and attendants. Dr. Lowsley, who will head the foundation, has had several years' special study in London and Paris in addition to his training at Bellevue and Johns Hopkins. He is now chief of the urological clinic of the New York Hospital, assistant surgeon of the department of urology of Bellevue Hospital, and clinical assistant of the Hospital for Ruptured and Crippled.

Southern States

The Riverside Hospital, a new institution, will be opened at Knoxville, Tenn., about September 1.

The War Department is having plans prepared for a 1,200-bed base hospital to be erected at Camp Sevier, near Greenville, S. C.

Twenty-two thousand dollars have been voted for an addition and other improvements at the City and County Hospital, Fort Worth, Tex.

Dr. Harlan L. Edwin and Dr. John C. Rollins, of Dalton, Ga., have announced their intention to establish a private hospital in that city.

The Presbyterian Hospital, Charlotte, N. C., has acquired the Elizabeth College building in that city and is having it improved for hospital use.

An addition is to be built to the State Lunatic Asylum at Austin, Tex., and the superintendent's residence at this institution remodeled in the near future.

An addition to contain a kitchen, dining room, dormitory, and accommodations for 25 patients is being planned for the City and County Hospital, Fort Worth, Tex.

The War Department is considering sites for a base hospital to be erected near Augusta, Ga. It is reported that this hospital will have a capacity of from 2,000 to 3,000 beds.

The New John Graves Ford Memorial Hospital, erected at Georgetown, Ky., at a cost of \$25,000, was formally opened in August. Miss Roma Lambert, of Findlay, O., is the superintendent.

The city council of Carrollton, Ga., has voted to accept a bequest of \$10,000 from the late C. B. Simonson toward the erection of a sanatorium. An additional expenditure of \$20,000 on the part of the city will be required.

Mrs. Pearl Landsberg has been supervisor of nurses at the Macon Hospital, Macon, Ga., since August 15, when she was appointed to succeed Miss Martha Redding, resigned. Miss Redding will take up private nursing in Macon.

Dr. William M. McCabe, for the last 27 years superintendent and surgeon of the Nashville City Hospital, Nashville, Tenn., has resigned and expects to go to France with the Vanderbilt hospital unit. Dr. William F. Fessey is the new superintendent at the City Hospital.

The Dallas (Tex.) Society for the Prevention of Tuberculosis is arranging to conduct free tuberculosis clinics in various parts of the city. All persons who have symptoms of tuberculosis are invited to be examined, and instruction as to the best methods of care and treatment will be given.

A modern building costing \$100,000 will be erected to replace the old home of the Illinois Central Hospital at Paducah, Ky., recently destroyed by fire. Construction work will be started as soon as the necessary preliminary work of drawing plans and awarding contract can be completed.

Miss Ida Jarman, a pupil nurse, and Miss Beulah Pate, also a nurse, were fatally burned at the Shoffner Hospital, Nashville, Tenn., July 22, when they accidentally set fire to a barrel of alcohol from which they were filling a bottle. One of the nurses lighted a match and the explosion followed. Both nurses died within six hours.

Miss Irma Lee O'Mara, a graduate of the Hattiesburg School for Nurses, Hattiesburg, Miss., for several years in charge of the hospital ward of the woman's college in that

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city, was appointed in August to the superintendency of the Hattiesburg Hospital, the position having been made vacant by the resignation of Miss Jennie M. Quinn.

Middle Western States

Dr. O. P. Jamison will open a new private hospital at Weldon, Iowa, September 1.

A new \$70,000 wing to St. Joseph's Hospital, Lorain, Ohio, was dedicated August 12.

Drs. Robert B. Clark and Wilson G. Bear will soon open a private hospital at Monroe, Wis.

The city of Okmulgee, Okla., received bids in August on the erection of a municipal hospital.

New quarters for the Huntington County Hospital, Huntington, Ind., will be opened in September.

An \$80,000 addition in course of construction for the Sacred Heart Hospital at Garrett, Ind., will soon be under roof.

Plans have been completed for an addition to be erected to the Chillicothe Hospital, Chillicothe, Ohio, in the near future.

A new wing to St. Joseph's Hospital, Lorain, Ohio, erected at a cost of \$70,000, was formally dedicated August 12.

The Ohio State Board of Administration has an appropriation of \$100,000 for the establishment of an institution for juvenile research.

Construction work was started in Sioux Falls, S. D., in August on a \$70,000 hospital for Dr. A. J. Moe, formerly of Heron Lake, Minn.

Dr. A. B. Ancker, on August 1, entered upon his thirty-fifth year as superintendent of the City and County Hospital at St. Paul, Minn.

The East Side Hospital, Toledo, Ohio, is being remodeled. Sun parlors and a pathological laboratory will be among the new features.

The Deaconess Hospital, East St. Louis, Ill., is having plans prepared for a nurses' home, which will be erected this fall at a cost of \$15,000.

A new home for the Jackson City Hospital, Jackson, Michigan, is nearing completion. The building will represent an expenditure of \$150,000.

A 48-bed isolation hospital, said to be thoroughly modern in construction and appointments, has recently been opened at the Iowa State University.

The Improved Order of Red Men has acquired the abandoned Mercy Hospital property at Jeffersonville, Ind., and is arranging to reopen the institution.

Contract has been let for the foundation and first floor of the proposed Ashland General Hospital at Ashland, Wis. A fund of \$40,000 was raised by popular subscription last fall to establish the hospital.

Dr. A. L. Gray, proprietor of Gray's Maternity Home, St. Joseph, Mo., is organizing a stock company to take over this institution and extend its usefulness. A new modern building to cost \$70,000 is planned.

Miss Minnie McEvoy, night superintendent at the Noyes Memorial Hospital, St. Joseph, Mo., has accepted an appointment as superintendent of the Whittington City Hospital, controlled by the St. Joseph health board.

A campaign was inaugurated by St. Olaf's Hospital at Austin, Minn., in August, to raise \$50,000 for a new main building. The patronage of the institution is said to be increasing to the extent that larger quarters are imperative.

A new company has been organized at Oshkosh, Wis., to take over the Lakeside Hospital of that city. The name of the institution will be changed to "Lakeside Methodist Hospital," it is said, and a training school for nurses established.

Contract has recently been awarded by St. Anthony's Hospital, Rock Island, Ill., for the erection of a \$200,000 building to replace the present home of the institution.